Supreme Court, U.S.
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No.

In The

Supreme Court of the United States

October Term, 1998

KMART CORPORATION, as Named Fiduciary of the Kmart Corporation Master Welfare Benefit Plan,

Petitioner,

vs.

DAVID SCHLEIBAUM, SANDY SCHLEIBAUM and JUDITH KIMMERLING,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

I. Whether the remedy for a Plan Administrator's breach of *statutory* duty under ERISA Section 502(a)(3), for failing to give adequate notice of the reason for a benefit denial, is limited to traditional equitable remedies and does not include compensatory or legal damages, as this Court has found for a breach of *fiduciary* duty under that same section?

II. Whether ERISA's fiduciary decision making principles require that new evidence, which has never been presented to the Plan Administrator entrusted with discretion to determine benefit eligibility, be evaluated in the first instance by the Plan Administrator on remand, rather than *de novo* by a reviewing court?

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

All parties are identified in the caption. Petitioner Kmart Corporation has no parent company. Its nonwholly owned subsidiaries are Kmart Far East Limited and Kmart Pharmacies, Inc. In addition, Kmart Corporation has a 49 percent equity holding in Meldisco subsidiaries of Footstar, Inc., the remaining shares being held by Footstar, Inc.

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Kmart Corporation, in its capacity as Life Insurance Plan Administrator, ("the Life Plan Administrator") petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit.

OPINIONS BELOW

The Entry of Findings of Fact and Conclusions of Law of the United States District Court for the Southern District of Indiana dated February 12, 1997 is unreported and is reprinted herein at Appendix D, *infra*. The Order on Plaintiff's Motion to Reconsider and Amend Judgment of the United States District Court for the Southern District of Indiana dated April 15, 1997 is unreported and is reprinted herein at Appendix C, *infra*. The Opinion of the United States Court of Appeals for the Seventh Circuit dated August 25, 1998 is reported at 153 F.3d 496 and is reprinted at Appendix A, *infra*. The Order of the United States Court of Appeals for the Seventh Circuit Denying Petition for Rehearing and Suggestion for Rehearing En Banc dated September 18, 1998 is unreported and is reprinted at Appendix F, *infra*.

STATEMENT OF JURISDICTION

The opinion of the United States Court of Appeals on which review is sought was decided on August 25, 1998. (Apps. A, B, *infra*). A Petition for Rehearing was timely filed on September 8, 1998, and denied on September 18, 1998. (App. F, *infra*). This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTES INVOLVED

Sections 502(a)(1) through (8) and 503 of the Employee Retirement Income Security Act ("ERISA") of 1974, as

amended, 29 U.S.C. §§ 1132(a)(1)-(8) and 1133, codify the remedy and notice provisions at issue here. These provisions are reprinted at Appendix G, *infra*.

STATEMENT OF THE CASE

The case involves two questions of great importance to the administration of ERISA employee welfare benefit plans. Rather than observing ERISA's carefully delineated remedial scheme and fundamental policy considerations, the Seventh Circuit made itself the administrator of an employee benefit plan in terms of both remedy and evidence. In so doing, it sharpened a divide among the Courts of Appeals concerning exactly what individual remedies are available when a plan administrator has been found to have violated a statutory (as opposed to a contractual or fiduciary) duty. It also imposed on plan administrators a standard of clairvoyance — a duty to rule out the possibility of medical conditions other than the one for which benefits have been sought, even though the plan administrator had no information or basis to suspect other conditions.

On the first point, the majority of the Courts of Appeals has held that compensatory or monetary relief is not available in the case of statutory notice violations, such as that at issue here. This result is in conformity with prior holdings of this Court that only traditional equitable remedies are available in breach of fiduciary duty actions under ERISA Section 502(a)(3). Because Section 502(a)(3) governs breaches of both *fiduciary* and *statutory* duties, the same result should apply to statutory notice violation cases. But this Court has not addressed this precise issue, and the Courts of Appeals' rulings on the issue exhibit a confusion that threatens efficient plan administration. Many of the Courts of Appeals' decisions, while refusing to award monetary and compensatory relief on the facts before

them, have observed in *dicta* that a court is free to impose compensatory or monetary relief when special circumstances exist. These deviant opinions, although *dicta*, jeopardized plan administration by suggesting significant compensatory (and even punitive) damages could be imposed on plan administrators at the seeming whim of the courts.

This *dicta* changed to binding precedent in the Seventh Circuit majority's opinion below. Apparently swayed by emotionally charged facts involving a plan participant's untimely death following his failure to qualify for a permanent and total disability life insurance benefit, the Seventh Circuit eschewed reliance on ERISA's integrated remedial scheme, and effectively ordered the district court to award monetary and compensatory relief even though the only alleged wrong by the plan administrator was a statutory notice violation (in denying benefits, the plan administrator had not provided adequate notice within the meaning of ERISA Section 503).

Moreover, the Seventh Circuit made this decision based on evidence of medical conditions other than the one for which benefits had been sought, evidence never presented to the plan administrator, thereby placing itself in the role of surrogate plan administrator. The Seventh Circuit's criticism of the plan administrator was not that it incorrectly interpreted the medical condition for which benefits had been sought. Rather, the plan administrator's failing, according to the Seventh Circuit, was that it did not rule out other medical conditions about which it knew nothing. The Seventh Circuit's usurpation of the plan administrator's fiduciary responsibility and discretion is in conflict with the holdings of the majority of Courts of Appeals that new evidence must be remanded to the plan administrator and that a reviewing court lacks authority to undertake the effort *de novo*.

This Court should grant a writ of certiorari to clarify ERISA law regarding a benefit plan's liability when its plan administrator breaches a statutory provision. While the Court has addressed liability for breaches of contractual or fiduciary duties, a benefit plan's liability in the case of statutory breaches has not been addressed by this Court and has been a source of confusion among the Courts of Appeals. The Court also should clarify the appropriate scope of a reviewing court's authority to consider new evidence in the first instance. Without clarification, the confusion and disagreement among the Courts of Appeals will lead to further deviancy and to an intolerable uncertainty for plan administrators. In light of the uncertainty that now exists, plan administrators cannot confidently and efficiently administer their benefit plans, to the detriment of all plan participants and beneficiaries.

A. Factual Background

In November 1991, Glen Schleibaum ("Mr. Schleibaum"), an automotive manager for Kmart Corporation ("Kmart"), took a medical leave of absence to undergo hip replacement surgery. (App., *infra*, at 30a). At the time, he was insured under Kmart's group life insurance plan ("the Life Plan") for both non-contributory and contributory coverage in the amount of $236,000 (subsequently increased automatically to $260,000). (App., *infra*, at 31a-33a). Mr. Schleibaum had enrolled in the contributory coverage when his wife was alive and named her as the sole beneficiary. When his wife died shortly before his medical leave, Mr. Schleibaum named Respondents, his adult children, as co-beneficiaries. (App., *infra*, 31a).

Under the terms of the Life Plan, Kmart, in its capacity as plan administrator ("the Life Plan Administrator"), assumed responsibility for all premiums during the one year that Mr. Schleibaum's coverage could continue automatically during his

medical leave under the Life Plan's group policy. (App., *infra*, at 33a). In order for Mr. Schleibaum's coverage and the Life Plan's payment of premiums to continue beyond this automatic one-year period, the Life Plan required medical evidence establishing that he qualified for the permanent and total disability benefit pursuant to the Life Plan's definition, that is —

> due to illness or injury, [the participant] is not engaged in his/her occupation or any other gainful occupation, and will continue to be unable, for life, to engage in any gainful occupation for which he/she is, or may reasonably become, fitted by education, training or experience.

(App., *infra*, at 42a-43a). In the event Mr. Schleibaum failed to satisfy this definition, the Life Plan offered a conversion option for all or any portion of Mr. Schleibaum's existing coverage. (App., *infra*, at 35a-36a).

After undergoing the hip surgery in December 1991, Mr. Schleibaum qualified for Social Security benefits and for benefits under Kmart's Long-Term Disability ("LTD") Plan (which is separate from the Life Plan). The standard for qualifying for Social Security and LTD benefits was less demanding than the qualifying standard for the permanent and total disability benefit, in terms of both duration and scope of the disability. (App., *infra*, at 32a). In addition, while both the LTD Plan and the Life Plan expressly entrusted their respective plan administrators with discretion to determine eligibility for benefits and to construe plan terms, the two plans were, in fact, administered by different entities, the LTD Plan being administered by Aetna rather than by Kmart. (App., *infra*, at 32a, 41a-42a).

The Life Plan Administrator determined that Mr. Schleibaum did not qualify for the permanent and total disability benefit under the Life Plan's definition, primarily because the attending physician's statement submitted by Mr. Schleibaum's hip surgeon expressed a durational limitation of only a few months rather than life. On August 28, 1992, the Life Plan Administrator formally notified Mr. Schleibaum that the medical evidence did not establish a permanent and total disability, and that his life coverage would cease in November 1992, at the end of the one-year automatic coverage period. The Life Plan Administrator further informed Mr. Schleibaum of his right to appeal this decision and the method for doing so, including the provision of additional medical reports, and advised of the availability of a conversion policy. (App., *infra*, at 34a-36a).

Mr. Schleibaum appealed this denial, in two separate submissions dated September 24 and October 26, 1992, providing two more documents in which his attending physician expressed the opinion that Mr. Schleibaum was improving and was capable of some sedentary work. While evidence at trial indicated that Mr. Schleibaum had earlier experienced other medical conditions, Mr. Schleibaum's submissions to the Life Plan Administrator, including the initial attending physician's statement, contained no indication of any medical problem other than Mr. Schleibaum's continuing recovery from hip surgery. (App., *infra*, at 7a-8a, 36a-39a, 44a). Mr. Schleibaum's last submission verified his understanding of his need to "do something about [his] life insurance" before it lapsed. (App., *infra*, at 39a).

The Life Plan Administrator responded to both submissions. On October 12, 1992, and in response to Mr. Schleibaum's request for information that he could take to his attending physician, the Life Plan Administrator affirmed the

benefit denial and provided Mr. Schleibaum with the Life Plan's defining standard in full:

> The provisions of the Group Term Life Insurance Policy are as follows: The term "permanently and totally disabled" means that the employee, due to illness or injury, is not engaged in her or any other gainful occupation, and will continue to be unable, for life, to engage in any gainful occupation for which she is, or may reasonably become, fitted by education or experience.

(App., *infra*, at 37a-38a). By letter dated November 3, 1992 and in response to Mr. Schleibaum's third submission, the Life Plan Administrator again affirmed the benefit denial, explaining that the attending physician's assessment that Mr. Schleibaum should be able to return to active employment, albeit "*sedentary*," did not satisfy the Life Plan's requirement that "the employee . . . continue to be unable, for life, to engage in *any gainful occupation*. . . ." (App., *infra*, at 38a, 40a) (emphasis in original).

The Life Plan Administrator received no further correspondence from Mr. Schleibaum, and Mr. Schleibaum chose not to purchase the available conversion policy for all or any part of his group coverage. His life coverage therefore automatically terminated in November 1992. (App., *infra*, at 41a-43a).

Unfortunately, Mr. Schleibaum died in September 1993 at the age of 60, almost a year after his life insurance coverage had terminated, from a cause of death (cerebral hemorrhage) unrelated to his hip surgery, from which he had continued to recover. (App., *infra*, at 43a-44a). Upon Mr. Schleibaum's death, Respondents received some $50,000 in proceeds from

Mr. Schleibaum's Kmart retirement savings plan and the proceeds of a small paid-up life insurance policy Mr. Schleibaum earlier had purchased through the Life Plan Administrator. (App., *infra*, at 41a).

B. The District Court Opinion

Respondents initiated this litigation under the Employee Retirement Income Security Act ("ERISA") of 1974, as amended, 29 U.S.C. § 1001 *et seq*., claiming that the Life Plan Administrator (1) denied the permanent and total disability benefit in violation of ERISA Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B); and (2) breached its fiduciary duty in violation of Section 502(a)(3), 29 U.S.C. § 1132(a)(3). The district court's jurisdiction thus was pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132. (App., *infra*, at 45a).

The district court denied the Life Plan's summary judgment motion and the case proceeded to a bench trial, where the district court did not find that the Life Plan Administrator had abused its discretion in denying the permanent and total disability benefit, meaning that it did not find a violation of Section 502(a)(1)(B). (App., *infra*, at 24a, 26a). Instead, the district court held only that the Life Plan Administrator had violated its statutory duty under ERISA Section 503, 29 U.S.C. § 1133, to provide adequate notice of the basis for the benefit denial. (App., *infra*, at 52a). According to the district court, the Life Plan Administrator's letters were too conclusory and, read together, provided no more than implicit notice of deficiencies in Mr. Schleibaum's claim. (App, *infra*, at 47a-49a). The district court also did not find, nor had Respondents alleged, that the Life Plan Administrator had acted in bad faith or engaged in active concealment, nor was there any evidence or finding of detrimental reliance. (App., *infra*, at 19a, 26a-27a).

As to available damages for a breach of statutory duty (the notice violation), the district court rejected the Life Plan Administrator's position that, in light of the new evidence at trial, the matter, including the new evidence, should be remanded for a redetermination by the Life Plan Administrator. Instead, the district court reviewed the new evidence *de novo*, and, taking it for granted that it could tell how the Life Plan Administrator would evaluate the new evidence, held that remand was not an appropriate remedy. (App., *infra* at 54a-55a). Instead of remand, the district court held, as it had signaled prior to trial, that a remedy akin to restitution for any life insurance premiums that would have been paid was the proper remedy. The district court observed that this restitution-like remedy was especially warranted given the Life Plan Administrator's status, not as the insurer, but as the payer of premiums, as well as the Life Plan Administrator's clear notice to Mr. Schleibaum that he needed to take some action if he wanted life insurance coverage after November 1992. (App., *infra*, at 25a-27a, 56a-57a). The district court reasoned that the face value of the policy, on the other hand, would constitute an essentially punitive remedy not envisioned or permitted by ERISA. (App., *infra*, at 25a-27a). Because Respondents had presented no evidence of the premium amounts, despite the district court's warnings that it considered this to be crucial evidence, the district court held that Respondents had failed to prove an element of their case. (App., *infra*, at 25a, 56a-57a). The district court thus entered judgment in the Life Plan's favor. (App., *infra*, at 58a-60a).

C. The Seventh Circuit Opinion

Respondents' appeal to the Seventh Circuit was pursuant to 28 U.S.C. § 1291. In its majority opinion, the Seventh Circuit agreed that the Life Plan Administrator had violated Section 503, because, while it had informed Mr. Schleibaum of his right

of appeal in its initial denial letter, it failed to repeat this notification in its subsequent letters to Mr. Schleibaum. (App., *infra*, at 6a). The Seventh Circuit majority also agreed that remand to the Life Plan Administrator was not necessary. (App., *infra*, at 14a-15a). However, the majority disagreed that the restitution-like remedy fashioned by the district court was an appropriate remedy. (App., *infra*, at 6a, 9a). Rather, the majority assumed, based on evidence never presented to the Life Plan Administrator, that Mr. Schleibaum could have qualified for the benefit due to medical conditions unknown to the Life Plan Administrator. (*Id.*). On this basis, the majority instructed the district court that it could (and should) award the life insurance benefit (or some portion of it), in light of Mr. Schleibaum's untimely death and in punishment for the Life Plan Administrator's notice violation. (App., *infra*, at 10a, 15a-17a).

In a carefully reasoned dissent, Judge Manion admonished the majority for imposing such an unprecedented remedy when "[e]veryone involved in this case concedes that at most Kmart violated § 1133 of the Act, meaning that it violated the technical notice requirements outlined by Congress." (App., *infra*, at 19a). This statutory violation, the dissent observed, did not warrant the remedy imposed by the majority absent evidence that Mr. Schleibaum actually would have qualified for the benefit had the Life Plan Administrator's letters included everything the majority thought the communications should have included:

> . . . Equity does not necessarily include forcing an employer to pay on a $260,000 life insurance policy (or some portion thereof) to the adult children of a deceased worker, Glen Schleibaum, simply because the company may have mailed cursory letters denying his claim of "total disability." . . . Even if Kmart's communications fell short of statutory technicalities, the plaintiffs' case fails to establish

> the basic element of causation — here, that Kmart's letters (rather than the circumstances) prevented their father from securing company-sponsored life insurance for their benefit before he died.

(App., *infra*, at 17a-18a).

The Seventh Circuit majority's holding is contrary not only to the holdings of the majority of other Courts of Appeals to have considered this issue, but also is incompatible with the holdings of this Court that compensatory or legal damages are not an available remedy under ERISA Section 502(a)(3). In addition, the holding eviscerates ERISA's carefully integrated remedial scheme and the trust principles in which ERISA is grounded.

REASONS FOR GRANTING THE WRIT

As this Court has recognized on many occasions, vital policy considerations governing fiduciary decision making are fundamental to ERISA and to employers' ability to offer and maintain effective benefit coverage for their employees. These policy considerations include consistency in interpretation and a resulting predictability of the risks in offering and administering a benefit plan. These considerations are implicit in ERISA's carefully delineated remedial scheme and the decisions of this Court that the remedial scheme is comprehensive and controlling on the issue of a plan's liability.

The precise questions at issue here have not been directly addressed by this Court. The Seventh Circuit's treatment of them (as well as similarly deviant treatment by a few other Courts of Appeals), suggest that they require this Court's attention, if consistency and predictability of benefits administration is to remain a viable concept.

I.

THE SEVENTH CIRCUIT DECIDED AN IMPORTANT QUESTION OF LAW IN A WAY THAT CONFLICTS WITH THIS COURT'S DECISIONS THAT ONLY TRADITIONAL EQUITABLE RELIEF IS AVAILABLE TO REMEDY AN INDIVIDUAL CLAIM FOR A PLAN ADMINISTRATOR'S BREACH OF A NON-CONTRACTUAL DUTY.

The remedy ordered by the Seventh Circuit decides an important question of federal law — that is, what is the appropriate remedy an individual beneficiary or participant may seek for a Section 503 violation — in a way that conflicts with the relevant decisions of this Court. Specifically, the Seventh Circuit's determination that compensatory damages or legal relief can be appropriate to remedy a plan administrator's statutory breach, conflicts with this Court's decisions in *Mertens v. Hewitt Associates*, 508 U.S. 248 (1993), as further refined by the Court in *Varity Corporation v. Howe*, 516 U.S. 489 (1996), that individual remedies for a plan administrator's breach of fiduciary duty are limited to traditional equitable relief.

As this Court made clear in *Mertens* and *Varity Corp.*, the only provision under which a plan participant or beneficiary can pursue an individual remedy for a plan administrator's non-contractual breach of duty is pursuant to ERISA Section 502(a)(3), the "catchall" provision enabling a participant or beneficiary to seek " 'appropriate equitable relief' for 'any' statutory violation." *Varity Corp.*, 516 U.S. at 512. *See also Mertens*, 508 U.S. at 253.[1] While these cases dealt with breaches

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1. Section 502(a)(3) authorizes:

> A civil action . . . by a participant, beneficiary, or fiduciary

(Cont'd)

of *fiduciary*, rather that *statutory*, duty, the provision expressly encompasses *both* types of duty and offers no basis for distinguishing between the two types.

This Court further has held that Section 502(a)(3)'s reference to equitable relief encompasses only those remedies "traditionally reviewed as 'equitable,' such as injunction or restitution." *Mertens*, 508 U.S. at 255. Equitable relief under Section 502(a)(3) does not include compensatory or money damages, nor may the limitation to equitable relief be avoided by incorrectly labeling relief that is monetary or compensatory *in fact* as equitable *in nature*. *Id.* at 255-58.

While the Seventh Circuit's majority opinion characterized the remedy it was ordering as "equitable," it really was, as the dissenting opinion pointed out, compensatory or monetary and therefore legal in nature: "Equity does not necessarily include forcing an employer to pay on a $260,000 life insurance policy (or some portion thereof). . . ." (App., *infra*, at 17a-18a). In remanding the matter to the district court, the majority instructed that court to award a remedy based on "the likelihood that Mr. Schleibaum had a legitimate claim" (in which case the majority instructed that the face value of the policy should be awarded), as well as the Life Plan Administrator's "fault," and

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(Cont'd)

> (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

29 U.S.C. § 1132(a)(3). (App., *infra*, at 63a-64a). The violation of Section 503 found by the district courts is a violation "of this subchapter," that is, of ERISA's Subchapter I, Protection of Employee Benefit Rights. (App., *infra*, at 63a-65a).

the fact that Mr. Schleibaum died "shortly after [the Life Plan Administrator] denied his claim." (App., *infra*, at 15a-17a). The majority effectively held that the district court must award the face amount of the life insurance benefit (or some portion of it) — monetary damages in the purest form — in a Section 502(a)(3) action. Indeed, in light of the Life Plan Administrator's status as a payer of premiums rather than an insurer, the majority instructed a remedy that was also punitive in nature.

In ordering the remedy, the Seventh Circuit majority did not even pay lip service to the limitations of ERISA Section 502(a)(3) or the decisions of this Court in *Mertens* and *Varity Corp.* Instead, it proceeded as if unconstrained by statute or precedent in its ability to order relief. But as this Court has made clear, the courts are always constrained by ERISA's remedial scheme. In *Massachusetts Mutual Life Insurance Company v. Russell*, 473 U.S. 134 (1985), this Court rejected the proposition that courts are free to fashion ERISA remedies at will. There, the respondent had argued that the remedy of extracontractual damages could be implied in Section 502(a)(1)(B) even though that ERISA provision did not expressly authorize such relief. This Court disagreed:

> The six carefully integrated civil enforcement provisions found in § 502(a) of the statute as finally enacted, however, provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly. The assumption of inadvertent omission is rendered especially suspect upon close consideration of ERISA's interlocking, interrelated, and interdependent remedial scheme, which is in turn part of a "comprehensive and reticulated statute."

Id. at 146 (quoting *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 361 (1980)). *See also Varity Corp.*, 516 U.S. at 515 ("We should expect that courts, in fashioning 'appropriate' equitable relief, will . . . respect the 'policy choices reflected in the inclusion of certain remedies and the exclusion of others' ") (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987)); *Mertens*, 508 U.S. at 257-58 (refusing to treat distinctions between relief available under other remedial provisions as "superfluous").

In conflict with the important principles identified by the Court in the context of fiduciary breaches, the Seventh Circuit held that the contractual compensatory relief reserved for Section 502(a)(1)(B) actions was available — in whole or in part — for a breach of Section 503. Because the remedy for this statutory breach is addressed only in Section 502(a)(3), the only remedies available to Respondents were those traditionally equitable in nature.

Respondents argued, and the Seventh Circuit majority agreed, that the resolution of the appropriate remedy in this case turned, not on ERISA's carefully integrated remedial scheme, but rather on "the primary purpose of ERISA, which is to protect the interests of plan beneficiaries." (App., *infra*, at 12a). But this Court has firmly rejected this argument:

> . . . vague notions of a statute's 'basic purpose' are . . . inadequate to overcome the words of its text regarding the specific issue under consideration. This is especially true with legislation such as ERISA, an enormously complex and detailed statute that resolved innumerable disputes between powerful competing interests — not all in favor of potential plaintiffs.

Mertens, 508 U.S. at 261-262 (citations omitted). In limiting the individual relief available for a plan administrator's breach of duty, Congress balanced " 'the tension between the primary [ERISA] goal of benefitting employees and the subsidiary goal of containing pension costs.' " *Id.* at 262-63 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981)). The Seventh Circuit was not free to adjust that balance.

In addition to conflicting with the decisions of this Court, the Seventh Circuit's holding is in conflict with the majority of the other Courts of Appeals that have addressed this issue. These conflicting cases are collected and summarized in *McLeod v. Oregon Lithoprint, Inc.*, 102 F.3d 376, 378 n.2 (9th Cir. 1996), *cert. denied*, __ U.S. __, 117 S. Ct. 1823, 137 L. Ed. 2d 1030 (1997), a case in which a plan participant raised a virtually identical argument. There, the plaintiff claimed that the plan's failure to notify her of her eligibility for cancer coverage entitled her to compensatory damages, including the benefits she would have received had she known of the coverage and enrolled in it. Because her only cause of action lay in Section 502(a)(3), the court held that such compensatory damages were not available. 102 F.3d at 378. In a subsequent case, the Ninth Circuit again held that Section 502(a)(3) relief *must* be limited to such traditional equitable remedies as injunction, mandamus or restitution, even where compensatory damages in one form or another constitute the only possible remedy for an alleged breach, meaning the restriction to an equitable remedy essentially forecloses any relief. *Bast v. Prudential Ins. Co. of America*, 150 F.3d 1003, 1009-11 (9th Cir. 1998). To allow a court to be moved by an untimely death, as was the case here and in *Bast*, would gut Congress' carefully integrated remedial scheme and the consistency and predictability it was intended to generate. *Id.*

The Seventh Circuit majority's holding at issue here crystalizes a deviancy from established ERISA principles that has led many courts to reach the right result, but for the wrong reason, and apparently led the Seventh Circuit here simply to reach a wrong result. This deviancy is reflected in those opinions that have precluded the award of a contractual or monetary remedy, not because of ERISA's express remedial scheme, but because the evidence did not establish that the statutory violation had involved bad faith, active concealment or detrimental reliance. *See, e.g., Kent v. United of Omaha Life Ins. Co.*, 96 F.3d 803, 807 (6th Cir. 1996) (observing that monetary relief for a statutory notice violation is available "only when some useful purpose would be served" and enumerating cases where a "useful purpose" (like a plan administrator's bad faith) was or was not served). This rationale conflicts with principles enunciated by this Court in *Russell*, *Mertens* and *Varity Corp.* and suggests a rule of law rife with unpredictability and inconsistency, leaving courts unconstrained by ERISA's carefully integrated remedial scheme.

These deviant Court of Appeals decisions arose primarily out of the Ninth Circuit's opinion in *Blau v. DelMonte Corp.*, 748 F.2d 1348 (9th Cir. 1984), *cert. denied*, 474 U.S. 865 (1985). That case, however, did not hold that the plan administrator's statutory notice violation, alone or in combination with the administrator's egregious bad faith, could *itself* require an award of compensatory or monetary relief. Rather, *Blau* held that a plan administrator's bad faith and active concealment, among many other deficiencies not involving statutory notice, could be evidence of an arbitrary and capricious benefit determination, resulting in a contractual breach remediable under ERISA Section 502(a)(1)(B). 748 F.2d at 1354. *Accord*, *Parker v. Bank America Corp.*, 50 F. 3d 757, 768-69 (9th Cir. 1995); *Berger v. Edgewater Steel Co.*, 911 F.2d 911, 920-21 (3rd Cir. 1990), *cert. denied*, 499 U.S. 920 (1991).

The two lines of reasoning depicted in Courts of Appeals decisions, exemplified on the one hand by *McLeod v. Oregon Lithoprint*, and on the other by *Kent v. United Omaha* and similar cases, represent a source of confusion regarding the appropriate remedy for a statutory notice violation. *McLeod* followed the principles announced by this Court in *Mertens* and *Varity Corp.*, while *Kent* and others, in contravention of those principles, took the position that the courts are unconstrained by ERISA's remedial scheme, at least where there is evidence of bad faith.

The Seventh Circuit majority took the *Kent* line of cases a step further, ignoring the constraints of ERISA's carefully integrated remedial scheme and the language of Section 502(a)(3) *even in the absence of evidence of bad faith, active concealment or detrimental reliance.* (App., *infra*, at 19a). Despite the fact that the district court did not find the Life Plan Administrator had acted arbitrarily and capriciously or had abused its discretion in denying the benefit, and despite the fact that the district court held only that the Life Plan Administrator had failed to provide adequate information, the Seventh Circuit majority effectively ordered a compensatory and monetary remedy.

To the extent *Kent* and other decisions arising out of *Blau* instilled in the Seventh Circuit the sense that it could depart at will from ERISA's explicit and integrated remedial scheme, it is appropriate for this Court to address exactly what standard the courts are to follow in remedying statutory notice violations. These are recurring issues in plan administration and ERISA litigation. Because the Seventh Circuit's opinion, in addition to conflicting with this Court's opinions on the remedial scope of ERISA Section 502(a)(3), conflicts with the opinions of many of its sister circuits and crystalizes a deviancy that has long confused this area of the law, it merits this Court's review.

II.

THE SEVENTH CIRCUIT DECIDED AN IMPORTANT QUESTION OF LAW IN A WAY THAT CONFLICTS WITH THE MAJORITY OF OTHER COURTS OF APPEALS BY HOLDING THAT NEW EVIDENCE THAT HAS NEVER BEEN PRESENTED TO A PLAN FIDUCIARY CAN SERVE AS A BASIS FOR JUDICIAL RELIEF WITHOUT REMANDING TO THE PLAN ADMINISTRATOR.

Contrary to the view of most of its sister circuits that a district court *may not* conduct a *de novo* review of new evidence to award ERISA benefits previously denied by a plan fiduciary, the Seventh Circuit majority held that the district court *must* rely on its *de novo* review of such evidence. To reach this result, the Seventh Circuit departed from established ERISA policies that require that any new evidence must first be remanded to the plan fiduciary whose responsibility it is — in the first instance — to determine eligibility. The Seventh Circuit's opinion again highlighted a split in the circuits on an important ERISA issue, which, like scope of remedy, is fundamental to consistency of interpretation and predictability of risk.

As this Court held in *Firestone Tire and Rubber Company v. Bruch*, 489 U.S. 101 (1989), "ERISA abounds with the language and terminology of trust law." *Id.* at 110. On this basis and as confirmed by ERISA's legislative history, certain basic trust principles are applicable in reviewing the actions of plan administrators, including principles that "make a deferential standard of review appropriate when a trustee exercises discretionary powers." *Id.* at 110-11. Thus, where a benefit plan has vested in its plan administrator the "discretionary authority to determine eligibility for benefits or to construe the terms of the plan," the plan administrator's eligibility determination is subject only to deferential review. *Id.* at 115.

Most of the Courts of Appeals have followed these principles in holding that, when a deferential standard of review applies, a reviewing court may not reverse the plan administrator's benefit determination based on evidence that was not before the plan administrator when he made his determination. *See, e.g.*, *Taft v. Equitable Life Assur. Society*, 9 F.3d 1469, 1471-72 (9th Cir. 1993) (collecting opinions of several other circuits). *See also Miller v. United Welfare Fund*, 72 F.3d 1066, 1071 (2nd Cir. 1995) (court reviewing plan administrator's actions under deferential standard cannot rely on evidence outside of the administrative record); *Quesinberry v. Life Ins. Co. of North America*, 987 F.2d 1017, 1022-25 (4th Cir. 1993) (impliedly affirming pre-*Firestone* case requiring remand to plan administrator rather than *de novo* review of additional evidence where review is pursuant to deferential standard).

The Second Circuit's opinion in *Miller v. United Welfare Benefit Plan*, 72 F.3d 1066, is illustrative of the trust principles that require remand to the plan administrator for consideration of new evidence rather than *de novo* consideration of the new evidence by the reviewing court. In *Miller*, the district court relied on new evidence to reverse a benefit plan's denial of benefits to a by-then deceased plan participant. *Id.* at 1069-70. The Second Circuit held that remand to the plan fiduciaries, rather than ordering the plan fiduciaries to pay benefits, was required: "[N]othing 'in the legislative history suggests that Congress intended the federal district courts would function as substitute plan administrators,' " nor is *de novo* review of extrinsic evidence consistent "with the ERISA 'goal of prompt resolution of claims by the fiduciary.' " *Id.* at 1071.

However, the Sixth (and now the Seventh) Circuits have rejected these established policies and created a split in the circuits by ordering that all or part of the contested benefits

could be paid based on evidence *never* presented to the plan administrator. The Sixth Circuit reached this result in *Vanderklok v. Provident Life and Accident Insurance Company*, 956 F.2d 610 (6th Cir. 1992), in which it held that new evidence did not require remand to the plan administrator. *Id.* at 617. Rather, the Sixth Circuit held that the district court could play the role of plan administrator, reviewing the old and the new evidence, because the plan administrator was at fault in violating ERISA's notice provisions. *Id.*

The Seventh Circuit majority's opinion at issue here is an even greater departure from the majority rule than *Vanderklok*. Acknowledging that the medical information submitted to the Life Plan Administrator put it on notice *only* of Mr. Schleibaum's hip condition, the Seventh Circuit nevertheless held that an award of benefits could be ordered based *solely* on evidence of other medical conditions, about which the Life Plan Administrator knew nothing. (App., *infra*, at 7a-8a, 16a-17a). Relying on *Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685 (7th Cir. 1992), *a case in which there was no new evidence to remand* (*id.* at 697), the Seventh Circuit majority essentially assumed the role of plan administrator, reviewed the new evidence, and fashioned a remedy based on that new evidence. (App., *infra*, at 14a-15a).

The Seventh Circuit's decision conflicts with the relevant opinions of this Court and several other Courts of Appeals for another reason. By requiring the district court to award monetary damages rather than remand to the Life Plan Administrator for a redetermination in light of the additional evidence, the Seventh Circuit has placed an untenable burden of "clairvoyance" on plan administrators.

Mr. Schleibaum sought the Life Plan benefit on the basis of his hip replacement, and the Seventh Circuit acknowledged

that the three medical submissions presented to the Life Plan Administrator provided notice of only that one medical condition. (App., *infra*, at 7a-8a). As Mr. Schleibaum's attending physician testified, the hip condition did not preclude Mr. Schleibaum from working in sedentary jobs, confirming that the Life Plan Administrator correctly interpreted the medical submissions it did receive. If Mr. Schleibaum was permanently and totally disabled prior to November 1992 when his insurance terminated — as the Seventh Circuit majority suggests — it was because of a condition about which the Life Plan Administrator knew nothing.

Heretofore, reviewing courts have recognized that plan administrators have authority to grant or deny benefit claims based on the medical condition for which benefits were sought — a standard that advances the vital policies of consistency in interpretation and predictability of risks. For example, in *Sandoval v. Aetna Life and Casualty Insurance Company*, 967 F.2d 377 (10th Cir. 1992), the plan administrator discontinued benefits, rightfully relying on evidence that the physical condition for which the LTD plan participant had sought benefits was no longer disabling. *Id.* at 378-81. The plan administrator was not required to ferret out evidence of other medical conditions, including, in that case, a psychological condition that did, at least eventually, render the plan participant totally disabled. *Id.* at 379-81.

Plan administrators also have been able — until the Seventh Circuit's decision — to reasonably rely on the medical opinions submitted to them, in terms of both accuracy and scope, a standard similarly respectful of the need for consistency and predictability in plan administration. For example, in *Taft v. Equitable Life Assurance Society*, 9 F.3d 1469 (9th Cir. 1994), the Ninth Circuit reversed a district court's award of benefits where the court's award was based on a physician's trial

testimony that he might have opined differently had he had more information or had better understood the scope of exactly what his opinion was to cover. *Id.* at 1471-72.

The Seventh Circuit majority criticized the Life Plan Administrator for failing to tell Mr. Schleibaum what medical information he needed to perfect his appeal. The problem is that the hip condition was the only medical issue identified for the Life Plan Administrator by Mr. Schleibaum or by his attending physician, and Mr. Schleibaum provided all of the medical information on his hip condition needed to perfect his appeal. The Life Plan Administrator was aware of no other condition. *Was the Life Plan Administrator to be clairvoyant?* The Seventh Circuit's ruling imposes on plan administrators a duty to rule out diagnoses other than the diagnosis for which the participant has sought benefits. This is incompatible with the need for consistency and predictability so fundamental to plan administration, and is an impossible standard for plan administrators to meet.

This Court has recognized that ERISA enunciates a vital policy interest in containing plan costs. *Mertens*, 508 U.S. at 262-63. *See also Varity Corp.*, 516 U.S. at 497 (acknowledging need to take into account Congress' "desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans"); *Parker v. Bank America Corp.*, 50 F.3d at 766 ("one of the goals of ERISA [is] to keep plan expenses within reason"). To require, as the Seventh Circuit did here, that a plan administrator essentially rule out medical diagnoses for which benefits have not been sought and which are unknown to the plan administrator, places an untenable cost burden on benefit plan administration. In addition, by effectively requiring plan administrators to insure against (and make decisions about) any possible latent condition or precursors to a future condition

about which the plan administrator (and possibly the plan participant) knows nothing, the Seventh Circuit is gutting predictability and encouraging litigation that is sure to affect the availability of benefit plans altogether, and that heretofore has been soundly rejected.

CONCLUSION

The Seventh Circuit majority's opinion decides two important federal questions in a way that conflicts with the relevant opinions of this Court and with the opinions of most of the Courts of Appeals. It also illuminates a deviant approach that has confused the analysis in several Courts of Appeals. It disregards vital ERISA policy considerations governing fiduciary decision making and ERISA's explicit remedial scheme. The Seventh Circuit's opinion in this case is worthy of this Court's review. Accordingly, the Life Plan Administrator respectfully requests this Court issue a Writ of Certiorari to the Seventh Circuit for a full review and, ultimately, reversal of that court's opinion.

Respectfully submitted,

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APPENDIX

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT DECIDED AUGUST 25, 1998

In the United States Court of Appeals

For the Seventh Circuit

No. 97-2202

DAVID SCHLEIBAUM, SANDY SCHLEIBAUM and JUDITH KIMMERLING,

Plaintiffs-Appellants,

v.

KMART CORPORATION, as Named Fiduciary of the Kmart Corporation Master Welfare Benefit Plan,

Defendant-Appellee.

Appeal from the United States District Court
for the Southern District of Indiana, Indianapolis Division.
No. 95 C 284—**David F. Hamilton,** *Judge.*

ARGUED JANUARY 7, 1998—DECIDED AUGUST 25, 1998

Before MANION, KANNE and ROVNER, *Circuit Judges.*

ROVNER, *Circuit Judge.* The untimely death of an ERISA claimant gave rise in this case to interesting questions about the appropriate remedy for a violation of 29 U.S.C. § 1133 (failure to give adequate notice of a denial of a claim for benefits) when a remand would be futile. One of the questions we must consider is whether a plaintiff in an ERISA action has a duty to mitigate damages when an employer provides inadequate notice of a denial of plan benefits. Only one other circuit has addressed the issue of mitigation in the context of ERISA and has concluded that a plaintiff has no such duty. We affirm the

district court's ruling that the employer here violated 29 U.S.C. § 1133 when it failed to give the claimant adequate notice of a denial of benefits. But we reverse the district court's holding that the only appropriate remedy was the cost of covering the insurance benefit, which, in effect, required the plaintiff to mitigate his damages.

I.

Glen Schleibaum worked for Kmart as an Automotive Manager.[1] In November 1991, he took an approved medical leave from his job in order to undergo hip replacement surgery. Unfortunately, the operation was not successful, and approximately one week after Mr. Schleibaum was released from the hospital, in January 1992, the hip socket dislocated and he returned to the hospital for further treatment. Mr. Schleibaum never completely recovered, and was subsequently found to be disabled for the purposes of Social Security disability benefits and for the purposes of Kmart's long-term disability insurance. He also held a life insurance policy through Kmart, and Kmart's benefit plan provided that if an employee suffered from a permanent and total disability, Kmart would continue to pay the life insurance premiums until the employee turned sixty-five. At the time of his hip replacement, Mr. Schleibaum was fifty-nine.

In August 1992, Kmart's benefits administrator informed Mr. Schleibaum by letter that, after reviewing the medical evidence, he found that Mr. Schleibaum was not permanently and totally disabled and that Kmart would not, therefore, continue to pay the premiums for the life insurance policy. The letter advised that Mr. Schleibaum should "forward any additional information or medical

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[1] We will refer to Glen Schleibaum as Mr. Schleibaum or the claimant hereafter. We will refer to David Schleibaum, Sandy Schleibaum and Judith Kimmerling as the Schleibaum children or the plaintiffs.

reports which you wish to have considered as part of your appeal." The conclusory letter did not explain any specific reason for the finding that Mr. Schleibaum was not disabled nor did it detail any particular information that could be submitted to cure the defect and perfect the claim. The letter informed Mr. Schleibaum that he could convert his coverage to an individual policy if he requested conversion within 31 days of the termination of his group policy. Mr. Schleibaum's group policy coverage was due to terminate in November 1992, after the completion of one year of approved medical leave. Mr. Schleibaum responded by supplying Kmart with a copy of the Attending Physician's Statement that Kmart required him to submit for his long-term disability benefits, which Kmart had approved. On the form, his physician indicated that Mr. Schleibaum had a "Class 4" level of impairment, meaning a "moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-70%)." Apparently confused by the form, the physician also indicated that Mr. Schleibaum was "totally disabled" from his current job and "any other work." In light of this apparent conflict in the medical evidence, Kmart again found that Mr. Schleibaum was not permanently and totally disabled, and denied his appeal. Once more, Kmart did not specify what information it required from Mr. Schleibaum to perfect his claim or why such information was necessary. Compounding the confusion was the fact that the plan did not define the term "totally and permanently disabled," and Mr. Schleibaum was apparently under the impression that if he was disabled for the purposes of Kmart's long-term disability policy and for the purposes of Social Security disability benefits, he was also disabled for the purposes of the life insurance plan.

Although Kmart did not inform Mr. Schleibaum of any continued right to appeal, he nevertheless tried again, this time including a letter from his physician stating that he would never "be able to return to active employment other than that of the most sedentary kind." Kmart responded by

quoting a Rule of Administration adopted by Kmart to define the terms of the Group Term Life Insurance policy: "The term 'permanently and totally disabled' means that the employee, due to illness or injury, is not engaged in his or any other gainful occupation, and will continue to be unable, for life, to engage in *any gainful occupation* for which he is, or may reasonably become, fitted by education, training or experience." *See* Appellant's Appendix 2, at 41 (emphasis in original). Kmart also cited the language from the physician's letter, stating that Mr. Schleibaum would be unable to return to active employment other than that of the most sedentary kind, implying that he would be able to engage in some, albeit sedentary, gainful employment. Again the letter did not inform Mr. Schleibaum of any right to appeal, and did not inform him what information he could submit to perfect his claim. At this point, Mr. Schleibaum gave up.

In May 1993, approximately six months after the last volley of letters, Mr. Schleibaum suffered a cerebral hemorrhage. He remained hospitalized until his death in September 1993. Mr. Schleibaum's policy, which would have been worth approximately $260,000 had it been in effect at the time of his death, named his adult children as beneficiaries. The Schleibaum children attempted to recover the benefits they believed were due under the policy whereupon Kmart informed them that it had not maintained the policy in light of its finding that Mr. Schleibaum was not totally and permanently disabled. The Schleibaum children then brought an action in federal court pursuant to ERISA. The action focused on Kmart's failure to give adequate notice of the reasons for denying coverage and its failure to inform Mr. Schleibaum of information necessary to make a meaningful appeal. As a result, the Schleibaum children argued, their father was wrongfully denied life insurance coverage, and they sought an award of the face value of the policy.

The district court found that Kmart had indeed violated 29 U.S.C. § 1133, the ERISA provision that requires the

plan administrator to provide adequate notice to a plan participant whose claim for benefits has been denied. That section requires the administrator to set "forth the specific reasons for such denial, written in a manner calculated to be understood by the participant." 29 U.S.C. § 1133(a). The provision also requires administrators to "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133(b). The district court found that Kmart failed on both counts by providing Mr. Schleibaum with only a cursory form letter that failed to detail the reasons for the denial or the specific materials the claimant could submit to perfect his claim. The district court also found, however, that although the notices were inadequate, Kmart did clearly inform Mr. Schleibaum that it intended to terminate his insurance coverage. The district court found, therefore, that the appropriate remedy was not the face value of the insurance policy, as the Schleibaum children requested, but rather the amount Mr. Schleibaum would have paid in premiums for an individual conversion policy available to him under Kmart's plan. Because the Schleibaum children presented no evidence regarding the amount of those premiums, the court found that they failed to prove the amount of damages and awarded them nothing. The Schleibaum children appealed.

II.

Kmart raises a weak challenge to the district court's finding that Kmart violated § 1133 of ERISA. The company admits it did not strictly comply with the statute but argues that it substantially complied by eventually providing all of the required information in a series of letters. *See Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 382 (7th Cir. 1994) (substantial compliance with ERISA regulations is sometimes sufficient to overcome procedural defects); *Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 693-94 (7th Cir. 1992) (substantial compliance with ERISA regula-

tions is sufficient, so long as the notice given provides the plan participant and the courts a sufficiently precise understanding of the ground for denial to permit a realistic opportunity for review). Although Kmart did eventually imply that the reason for the denial of benefits was Mr. Schleibaum's residual capacity to perform some sedentary work, Kmart never told Mr. Schleibaum what medical information to submit to perfect his claim.

Most importantly, Kmart did not impart this critical information to the claimant at a time when he could have still done something about it. In the second and third letters, Kmart merely informed Mr. Schleibaum that it was denying his claim, and did not inform him, as the company had in the first letter, that he had a right to appeal. As a result, Mr. Schleibaum gave up his appeal and failed to gather the additional information that could have helped him perfect his claim. As the district court aptly pointed out, the ERISA claims process is not designed to be an endurance contest, where an employee must continue to appeal, without knowing what information the employer requires or whether the employer will even consider the appeal. *Schleibaum v. Kmart Corp.*, No. IP95-284-C H/G, slip op. at 18 (S.D. Ind. Feb. 12, 1997). Under *Donato* and *Halpin*, the plan participant must have all the necessary information at a time when the participant still has a meaningful opportunity for appeal and for full and fair review. *Donato*, 19 F.3d at 382; *Halpin*, 962 F.2d at 697. Kmart fell far short of meeting the standard for substantial compliance and we thus affirm that portion of the district court's ruling.[2]

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[2] Contrary to our dissenting colleague's claim, the plaintiffs clearly convinced the district court that Kmart's denial letters were to blame. The district court held that "[i]n denying Mr. Schleibaum the continued life insurance premium coverage based on disability, Kmart violated his rights to meaningful notice under ERISA." *Schleibaum*, slip op. at 14. The court also found that the "denial letter was about as conclusory as could be

(continued...)

III.

The appropriate remedy for Kmart's violation of § 1133 is a much more difficult issue. The district court found that because of Mr. Schleibaum's death, it was impossible to determine whether he was in fact permanently and totally disabled, pursuant to the plan's definition of those terms, in the fall of 1992. *Schleibaum*, slip op. at 21. Mr. Schleibaum's medical condition at that time could no longer be assessed with any degree of certainty, and the court had no way to assess his employability, the standard that Kmart applies in determining disability for this purpose. *Id.*, slip op. at 21-22. The district court also found that Kmart was responsible for this lack of information, having failed in its letters to Mr. Schleibaum to request the information it required to make the proper assessment. *Id.*, slip op. at 21. Because Mr. Schleibaum suffered from other serious medical conditions in addition to the failed hip replacement, this information could well have resulted in a finding of disability by Kmart's administrator.[3] The physician who evaluated Mr. Schleibaum considered only his hip problem in concluding that the claimant would not be able to perform anything other than the most sedentary

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[2] (...continued)
imagined," and that because of the inadequacies in the letters, Mr. Schleibaum did not understand the basis for Kmart's denial of his claim. *Id.*, slip op. at 16.

[3] In addition to the failed hip replacement, the record reveals that Mr. Schleibaum suffered from a heart condition for which he had undergone an angioplasty in 1988, that he was obese, and that he had a problem with blood clots that required him to take blood thinners on a regular basis. In 1991, Mr. Schleibaum collapsed at work due to a blood clot in his neck, an incident which required hospitalization for treatment. The district court also noted that Mr. Schleibaum continued to have "substantial limits on his stamina" several months after the hip replacement surgery, and remarked that limited stamina can "easily make the difference as to whether a person is able to engage in gainful employment." *Schleibaum*, slip op. at 22.

work. That physician has since testified in his deposition that he cannot now form an opinion as to whether Mr. Schleibaum was permanently and totally disabled according to Kmart's definition as of fall 1992. Kmart's benefits administrator was also unaware of these additional medical conditions at the time he denied benefits.

Had the administrator provided specific reasons for the denial, Mr. Schleibaum might have been able to obtain an assessment that accounted for his complete medical status and included an analysis of his capacity to engage in gainful employment. The court opined that the problem was one of burden of proof. The beneficiaries of the employee could not prove that he was disabled and the plan administrator could not prove that he was not. The court assumed that the burden of proof regarding Mr. Schleibaum's condition should fall on Kmart. The court also assumed, *arguendo,* that it had the power to determine *de novo* Mr. Schleibaum's eligibility for benefits rather than remanding to the plan administrator for that determination.

Having made those assumptions, however, the court declined to award the Schleibaum children the face value of the policy, holding that, although the notice provided was faulty, Kmart did inform Mr. Schleibaum that he would not be covered and that he could purchase a conversion policy. The district court found that purchasing the conversion policy was a "reasonable and practical" alternative for Mr. Schleibaum, and that he could afford to pay for it with his disability income from Social Security and Kmart's long-term disability plan, as well as his retirement savings account. The court found that the lapse in coverage was Mr. Schleibaum's own choice, and the maximum amount recoverable by his beneficiaries was the cost of the premiums for the conversion policy. Because the Schleibaum children failed to put on any evidence regarding the amount of those premiums, the court held that they failed in their proof of the amount of damages, and the court entered judgment for Kmart.

A.

As the district court noted, the damages issue here is complex. But we do not agree that the appropriate measure of damages was the amount of the premiums for the conversion policy. Nor do we agree that the plaintiffs are at fault for a failure of proof on this amount. We will begin by addressing an evidentiary problem in the court's analysis. Although the district court found that there was no evidence regarding the cost of a conversion policy, the court ruled that paying for such a policy was a "reasonable and practical" alternative for Mr. Schleibaum. The court based this finding on the fact that Mr. Schleibaum was receiving a little more than $3000 per month in disability payments, and the fact that he had approximately $50,000 in a retirement savings account with his former employer. We are perplexed by the district court's finding that Mr. Schleibaum could pay for premiums when it also found that there was no evidence in the record regarding how much the conversion policy would have cost. We suspect that life insurance premiums for a fifty-nine-year-old man who suffered from a failed hip replacement, obesity, a heart condition and a blood clot disorder would not have been insignificant. Moreover, even if the court knew the cost of the premiums, it had no information regarding Mr. Schleibaum's monthly expenses, and no evidence that Mr. Schleibaum had access, at age fifty-nine, to his retirement account. With no support in the record for the amount for the premiums or Mr. Schleibaum's ability to pay, the district court's finding that the conversion policy was a "practical and reasonable alternative" for Mr. Schleibaum was in error. *See Hamilton v. Mecca, Inc.*, 930 F. Supp. 1540, 1555 (S.D. Ga. 1996) (rejecting defendant's theory that plaintiff should have mitigated ERISA damages by maintaining conversion policy).

A more fundamental problem with the district court's holding is that mitigation of damages is generally an affirmative defense for which the defendant bears the burden

of proof. *See e.g. Fleming v. County of Kane, State of Illinois*, 898 F.2d 553, 560 (7th Cir. 1990) (in employment discrimination cases, once plaintiff has established lost wages, the burden shifts to defendant to prove as an affirmative defense that plaintiff failed to mitigate those damages). Having proved their theory of damages, i.e., the face value of the policy, the Schleibaum children had met their burden. The burden then shifted to the defendant to show that Mr. Schleibaum could have mitigated his damages. Kmart should have borne the burden of proof on the amount of the conversion premiums and whether Mr. Schleibaum could have afforded them given his income and expenses. Instead, the court faulted the Schleibaum children for not putting on evidence regarding the amount of the premiums, hypothesizing that the children did not bother to put on premium evidence because they "understandably have had little interest in pursuing this case to obtain the meager benefits of a few months' worth of life insurance premiums." *Schleibaum*, slip op. at 25. The court thus erred by placing the burden of proof on mitigation on the plaintiffs. *See Hamilton*, 930 F. Supp. at 1554.[4]

Whether plaintiffs are even required to mitigate their damages in the ERISA context is not a settled matter of law. Very few courts have addressed mitigation of damages in the context of ERISA. Neither party cites a case directly

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[4] In *Hamilton*, the employer failed to provide the employee with notice of his right to continuation of coverage under COBRA, and as a result, the employee incurred un-reimbursed medical expenses. 930 F. Supp. at 1554. The court there noted that in order to maintain a conversion policy, the employee would be required to pay significantly higher monthly premiums at a time when he could ill afford additional expenses, as was likely the case with Mr. Schleibaum. The court held that the plaintiff was not obliged to undertake such a burden in order to mitigate his damages. *Id.*, 930 F. Supp. at 1555. In the instant case, the district court speculated that Mr. Schleibaum could have afforded the expense of a conversion policy. Because the burden of proof rested on the defendant on this point, that ruling was in error.

on point. We were able to find only one federal circuit that addressed this issue, albeit in a slightly different context. In *Moothart v. Bell*, 21 F.3d 1499 (10th Cir. 1994), a plan administrator refused to provide a copy of the plan summary to an employee despite repeated requests. The employee sued under § 1132(c), which provides for a penalty for each day that passes after the date of the failure or refusal to provide a plan participant with a copy of the plan. The district court imposed a penalty that covered the period of time between the first request for a copy of the plan summary and the date of trial, when the defendant finally produced the requested document. The defendants complained on appeal that the district court failed to consider and apply the doctrine of mitigation of damages. The Tenth Circuit rejected that argument outright:

> First, we emphasize that the penalty statute is just that, a penalty. Therefore, mitigation of damages would not apply. *See Daugherty*, 3 F.3d at 1494 ("section 1132(c) is intended to punish non-compliance with the employer or administrator's disclosure obligations and not to compensate the participant"). The focus is necessarily on the plan administrator's actions, not the participant's.

Moothart, 21 F.3d at 1506-07.[5] Of course, we are not dealing with the penalty statute here. Kmart's obligation to provide adequate notice of the specific reasons for denial of a benefit arose under §1133, and the Schleibaum children sued under § 1132(a) to recover benefits due under the plan. The statutory penalty under § 1132(c) applies only when an administrator refuses to supply information that the administrator is obliged to provide under ERISA. *See Dade v. Sherwin-Williams Co.*, 128 F.3d 1135, 1143

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[5] *See also Iron Workers' Local No. 25 Pension Fund v. Klassic Services, Inc.*, 913 F. Supp. 541 (E.D. Mich. 1996) (in an ERISA action to collect delinquent fringe benefits, duty to mitigate did not apply when defendant did not allege how plaintiff could have avoided accumulation of damages).

(7th Cir. 1997) (statutory penalty imposed pursuant to § 1132(c) not available for violations of § 1133); *Vander-Klok v. Provident Life and Accident Ins. Co, Inc.*, 956 F.2d 610, 617-18 (6th Cir. 1992) (same).[6]

But as with the statutory penalty, the focus of § 1133 is on the plan's actions, and not on the plan participant. Thus, the rationale applied in § 1132(c) actions to reject the defense of mitigation is also applicable to § 1133. Requiring mitigation, in this instance, also seems inconsistent with the primary purpose of ERISA, which is to protect the interests of plan beneficiaries. *Leigh v. Engle*, 727 F.2d 113, 139 (7th Cir. 1984). *See also Buckley Dement, Inc. v. Travelers Plan Administrators of Illinois, Inc.*, 39 F.3d 784, 789 (7th Cir. 1994) (" 'ERISA is a comprehensive statute designed to promote the interests of employees and their beneficiaries' in pension and welfare benefit plans." (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983))). When the wrongful act of the employer is a failure to provide information that is solely within the employer's control, employees would be hard pressed to "mitigate" in the traditional sense by seeking out the information themselves.

Here, the court went a step further and faulted the employee for failing to cover his potential losses by purchasing a conversion policy at a time when the employee

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[6] Section 1133 defines the obligation of the *plan* to provide adequate notice to a plan participant of the reasons for a denial of benefits, and to also provide a reasonable opportunity for a full and fair review of a decision denying benefits. Section 1132(c) sets a penalty for a failure of a *plan administrator* to supply requested information, such as a copy of the plan. Although both sections address a failure to provide information, the obligation to provide the information applies to different entities, the remedies differ, and the likely harm to the plan participant also differs. The common element that is relevant here is that both sections focus on the actions not of the plan participant but rather on the actions of the plan and its administrator.

had not yet realized that the plan administrator had breached its duties. Requiring mitigation by a plan participant might, in fact, serve as a disincentive to plan administrators to comply with the procedural requirements of ERISA. This case provides a perfect illustration of the problem. If the claimant is required to mitigate, then the claimant is required to pay for coverage while appealing the denial of benefits. The claimant must do so even though the claimant may not realize that the administrator has provided inadequate notice, and may not even realize he or she has a reason or a right to appeal. If found liable after the appeal, the administrator will be forced to reimburse the claimant for the cost of coverage, which is all the administrator would have had to pay in the first place. We do not see how such a requirement would promote the interests of employees in benefit plans.

B.

So what is the appropriate measure of damages in this case? Normally, in an action for an inadequate denial letter, the remedy is to remand the case to the administrator for a full and fair hearing of the claim, and that is the remedy that Kmart urges us to grant if we are inclined to grant any remedy at all. *See Wolfe v. J.C. Penney Co., Inc.*, 710 F.2d 388, 393 (7th Cir. 1983). Kmart relies on *Wolfe*, where the plan administrator denied the plaintiff's claim for long-term disability benefits. We held there that the letter denying benefits did not pass muster under § 1133 because it was conclusory, and contained only a blanket request for further "medical information." *Id.*, 710 F.2d at 392-93. We characterized the plan administrator's error as procedural in nature. The record in the district court suggested that if the plaintiff had received adequate notice, he would have been able to supplement the record and would have been able to seek full and fair review of his claim. We held, therefore, that although the plaintiff was not entitled to a substantive remedy for this procedural violation, he was entitled to a remand to the plan

fiduciary for a new determination of his claim. *Id.*, 710 F.2d at 393. *See also Gallo v. Amoco Corp.*, 102 F.3d 918, 923 (7th Cir. 1997), *cert. denied*, 117 S. Ct. 2532 (1997) (the remedy when a plan administrator fails to make adequate findings or to explain its grounds adequately is to send the case back to the administrator for further findings or explanation; this is the appropriate remedy in an ERISA action unless the case is so clear-cut that it would be unreasonable for the administrator to deny the application for benefits on any ground). No remand is necessary, of course, where it would be a useless formality. *Wolfe*, 710 F.2d at 394. Finally, we held that if the plaintiff prevailed in the hearing before the plan fiduciary, he was entitled to retroactive benefits. *Id.*

Kmart urges that *Wolfe* is controlling here, and that under *Wolfe*, the only remedy available is remand to the plan fiduciary to hear the claim again. Kmart attempts to distinguish *Halpin v. W.W. Grainger*, 962 F.2d 685 (7th Cir. 1992), where we held that in some cases, reinstatement in the plan rather than remand for a hearing, was the appropriate remedy when the administrator issued an inadequate letter denying benefits. Halpin's plan administrator terminated his disability benefits, having previously found that he was eligible. We affirmed the district court's judgment that the letter terminating the benefits did not comply with § 1133. We also held that the district court did not abuse its discretion by ordering reinstatement of benefits instead of a remand for a hearing before the fiduciary. *Halpin*, 962 F.2d at 697. A remand was not necessary in that case because the administrator had previously determined that the claimant was eligible for benefits, and because the claimant did not have additional evidence to present on the merits of the claim. We explained that when additional evidence on the merits is presented for the first time to the district court, the court should remand to the fiduciary to make an initial assessment of whether the additional facts establish eligibility. *Id.*

The district court in the instant case found that Mr. Schleibaum's claim fell in between *Wolfe* and *Halpin*. We agree with the district court that a remand was not required under *Wolfe* because a remand would be futile. *Wolfe*, 710 F.2d at 393 (remand not required where it would be a useless formality). The Schleibaum children could no longer gather evidence about their father's medical condition and employability because of his untimely death. In fact, the district court remarked that Kmart had made clear "that it could not determine that Mr. Schleibaum was eligible for benefits without seeing new evidence of a type that plaintiffs cannot possibly find or produce." *Schleibaum*, slip op. at 23. But reinstatement under *Halpin* was not necessarily appropriate because Mr. Schleibaum had never been adjudged eligible for continuation of his life insurance benefits in the first place. It was this quandary that led the district court to hold that the appropriate measure of damages was the cost of conversion policy premiums. As we noted above, this holding was in error because it required the plaintiff to mitigate his damages when, among other things, the defendant failed to prove that the claimant could have mitigated the damages.

The puzzle here is that if Mr. Schleibaum was entitled to a continuation of his life insurance, then the appropriate remedy would be the face value of the policy. *See* 29 U.S.C. § 1132(a)(1)(B) (a plan participant may bring an action to recover benefits due to him or her under the terms of the plan); *Wolfe*, 710 F.2d at 394 (plaintiff is entitled to retroactive benefits if he or she prevails on remand in a § 1133 claim); *Hamilton*, 930 F. Supp. at 1574 (appropriate remedy for administrator's failure to provide plaintiff adequate notice of his right to continued coverage under COBRA is the total amount of medical expenses that were not reimbursed as a result of defendant's failure). If he was not entitled to continuation of the life insurance, then his beneficiaries are not entitled to a substantive remedy. *See Wolfe*, 710 F.2d at 393 (plaintiff not entitled to a substantive remedy based on defendant's procedural ERISA

violation); *Kent v. United of Omaha Life Ins. Co.*, 96 F.3d 803, 807 (6th Cir. 1996) (generally, procedural violations in ERISA do not give rise to substantive remedies); *Parker v. BankAmerica Corp.*, 50 F.3d 757, 768 (9th Cir. 1995) (ordinarily, a plaintiff who suffers because of a fiduciary's failure to comply with ERISA's procedural requirements is entitled to no substantive remedy). But we do not know, and agree with the district court that we cannot now determine whether Mr. Schleibaum was in fact totally and permanently disabled and therefore entitled to continuation of the policy. We do know that Mr. Schleibaum had a non-trivial claim for continuation of his life insurance coverage. He had already been adjudged disabled for the purpose of Social Security disability benefits and for the purpose of Kmart's long-term disability program.[7] In that sense, his situation was closer to *Halpin* than to *Wolfe*. That there are gaps in the information regarding his employability and medical condition is largely due to Kmart's failure to inform Mr. Schleibaum about the information he needed to perfect his claim, combined with Mr. Schleibaum's untimely death. The district court must therefore exercise its equitable powers in fashioning an appropriate measure of damages. *See Parker*, 50 F.3d at 769 (plaintiff entitled to recover benefits when he or she can show that a procedural ERISA violation caused a substantive harm); *Kent*, 96 F.3d at 807 (in ERISA cases, procedural violations entail substantive remedies when some useful purpose would be served). In determining the amount to award, the court should consider the likelihood that Mr. Schleibaum had a

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[7] Given the findings of the Social Security Administration and the long-term disability insurance carrier, as well as the record evidence of Mr. Schleibaum's myriad medical problems, we are puzzled by the dissent's claim that "the evidence suggests that the problem was Schleibaum's medical substantiation, not his misunderstanding of the documentation Kmart required." *See infra* at 19. This statement is also contrary to the district court's finding regarding what Mr. Schleibaum understood about Kmart's requirements. *See* Note 2, *supra*.

legitimate claim and would have been covered but for the fact that Kmart provided inadequate notice of the denial of the claim. The court should also consider the degree of fault to be assigned to Kmart for its failure to properly inform Mr. Schleibaum about how to perfect his claim in time for him to do so. Finally, the court should consider that Kmart's error was procedural in nature, but may have led to a substantive harm. This is a difficult calculus to apply in hindsight, given that we now know Mr. Schleibaum's health problems were serious enough to result in his death shortly after Kmart denied his claim. But deciding what is fair is the kind of assessment district courts must make every day. We are confident that the district court here, having tried the case, is in the best position to make that equitable assessment.

On one final note, plaintiffs also appealed the district court's denial of attorney's fees and costs. The district court found that plaintiffs were not entitled to fees and costs in view of their "lack of ultimate success on the merits." *Schleibaum*, slip op. at 25. In light of our ruling today, we direct the district court to reconsider the issue of fees and costs. *See* 29 U.S.C. § 1132(g)(1); *Filipowicz v. American Stores Benefit Plans Committee*, 56 F.3d 807, 816 (7th Cir. 1995) (setting forth the factors a court should consider in determining whether to award attorney's fees in an ERISA action). Costs on appeal are awarded in favor of the plaintiffs.

AFFIRMED IN PART,
REVERSED IN PART,
AND REMANDED.

MANION, *Circuit Judge*, dissenting. I respectfully dissent from the court's decision to remand this case to the district court. After one trial it is doubtful further proceedings will enlighten the district court on how to enhance a judgment this court believes could be more "fair" and "equitable." Equity does not necessarily include forcing an employer to

pay on a $260,000 life insurance policy (or some portion thereof) to the adult children of a deceased worker, Glen Schleibaum, simply because the company may have mailed cursory letters denying his claim of "total disability." In fact, as the court concedes, Kmart's very first letter to Schleibaum notified him of his right to appeal and subsequent letters explained that Kmart did not view him as disabled because he could perform some kinds of work if not all kinds. We need not decide whether Kmart's series of letters "substantially complied" with the Act, thus satisfying all of its obligations under ERISA. Even if Kmart's communications fell short of statutory technicalities, the plaintiffs' case fails to establish the basic element of causation—here, that Kmart's letters (rather than other circumstances) prevented their father from securing company-sponsored life insurance for their benefit before he died.

Consider the possibilities, already adjudicated before the district court. Faced with the prospect of continuing his life insurance through an individual policy (and the monthly premiums that he would have to personally pay), Schleibaum might well have decided that the costs exceeded the benefits; his children, after all, were fully grown. He may well have decided that he could better use his money for immediate needs or desires for himself or others rather than pouring it into life insurance. In that case, he might have made a conscious decision not to continue the life insurance while at the same time pursuing the chance that the company might reconsider its decision that he was not "permanently and totally disabled."

But giving the adult children the benefit of all doubts, suppose their father decided against the individual policy because neither he nor his children could afford it, but still wanted to provide for them after his death. In that case his only chance to obtain coverage was to convince Kmart that—despite the evidence to the contrary (his doctor's letter stating he could perform sedentary work)—he was indeed permanently and totally disabled under the terms of the plan. He died before he could convince Kmart of

this. The court focuses on Kmart's letters rather than the lack of medical documentation supporting Schleibaum's claim. We will never know whether more complete communication between Kmart and Schleibaum would have resulted in Kmart accepting his claim of disability (the evidence suggests that the problem was Schleibaum's medical substantiation, not his misunderstanding of the documentation Kmart required).

Rather than rooting its opinion in arguable notions of what "equity" demands, the court should stick close to the law. Everyone involved with this case concedes that at most Kmart violated § 1133 of the Act, meaning it violated the technical notice requirements outlined by Congress. Nowhere does the court acknowledge that in these cases "[w]e have repeatedly held that technical violations of ERISA's notification requirements, without a showing of bad faith, active concealment or detrimental reliance, do not state a cause of action." *Anderson v. Chrysler Corp.*, 99 F.3d 846, 859 (7th Cir. 1996) (citations omitted). The plaintiffs do not contend that Kmart is guilty of bad faith or active concealment of any material information, and nothing uncovered during the trial suggested it. That leaves the plaintiffs' last chance to recover under their father's life insurance policy—they must prove that Kmart falsely summarized the plan and induced their father to rely on those representations. But the plaintiffs did not pursue this theory in the district court, and in all events the record evidence establishes that while Kmart's letters were somewhat cursory, they were not misleading in any way. In fact, Schleibaum's own letters reveal his understanding that his claim had been rejected because the company did not view him as disabled under the terms of the plan.

The court concedes that we will never know whether Mr. Schleibaum was in fact permanently and totally disabled and entitled to a continuation of his policy. We will never know whether more complete notices mailed by Kmart would have prompted Schleibaum to provide more convincing medical evidence, or whether he shared everything he

had with Kmart before he died. We will never know why he decided not to continue his life insurance by converting to an individual policy, whether he intended his adult children to benefit from a policy, or whether he pursued his disability claim only because he had nothing to lose. After taking much evidence, we still do not know much; a remand will not cast new light on the same facts. We are not deciding whether there is a genuine issue about these things; the plaintiffs already had their day in court and failed to convince the district court that the letters were to blame. Fairly, equitably, and most important, legally, that failure should put an end to their case. For these reasons, I dissent.

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

APPENDIX B — JUDGMENT OF UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT DATED AUGUST 25, 1998

UNITED STATES COURT OF APPEALS
For The Seventh Circuit
Chicago, Illinois 60604

JUDGMENT — WITH ORAL ARGUMENT

Date: August 25, 1998

BEFORE: Honorable DANIEL A. MANION, Circuit Judge
Honorable MICHAEL S. KANNE, Circuit Judge
Honorable ILANA DIAMOND ROVNER, Circuit Judge

No. 97-2202

DAVID SCHLEIBAUM, SANDY SCHLEIBAUM and JUDITH KIMMERLING,

Plaintiffs - Appellants

v.

KMART CORPORATION, as Named Fiduciary of the Kmart Corporation Master Welfare Benefit Plan,

Defendant - Appellee

Appeal from the United States District Court for the Southern District of Indiana, Indianapolis Division
No. 95 C 284, David F. Hamilton, Judge

Appendix B

The judgment of the District Court is AFFIRMED in part, REVERSED in part, and REMANDED. Costs on appeal are awarded in favor of the plaintiffs. The above is in accordance with the decision of this court entered on this date.

APPENDIX C — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF INDIANA, INDIANAPOLIS DIVISION FILED APRIL 15, 1997

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

CAUSE NO. IP 95-284-C H/G

DAVID SCHLEIBAUM, SANDY SCHLEIBAUM, and JUDITH KIMMERLING,

Plaintiffs,

v.

KMART CORPORATION, as named Fiduciary of the Kmart Corporation Master Welfare Benefit Plan,

Defendant.

ORDER ON PLAINTIFF'S MOTION TO RECONSIDER AND AMEND JUDGMENT

The court entered final judgment for defendant Kmart Corporation in this action on February 12, 1997. Plaintiffs filed a timely motion under Rule 59 asking the court to reconsider its decision and to enter judgment in their favor. Kmart has responded to the motion. The court has already issued two relatively detailed opinions in this case. For the reasons explained briefly below, plaintiffs' motion is denied.

Appendix C

Based on the nature of the employee benefit as issue here — employer payment of life insurance premiums for employees who were disabled — and the alleged wrongful denial of it, the court explained in its findings of fact and conclusions of law that the greatest remedy to which plaintiffs might be entitled would be the value of the life insurance premiums that Glen Schleibaum would have had to pay if he had exercised his option to convert the group policy to an individual policy. Because plaintiffs did not offer evidence of the amount of those premiums, the court entered judgment for defendant without resolving several other contested issues, including whether the denial of benefits was actually a breach of Kmart's obligations under the employee welfare benefit plan. In their Rule 59 motion, plaintiffs have raised two arguments seeking two different types of relief on the merits. They have also asked the court to reconsider its denial of an attorney fee award.

First, plaintiffs contend that they did indeed offer evidence of the amount of life insurance premiums that Glen Schleibaum would have been entitled to have Kmart pay from November 1992 until his death in September 1993. Plaintiffs direct the court's attention to Exhibit 26, which contains a table of premiums for each $1,000 of life insurance coverage by age. In the brief in support of their Rule 59 motion, plaintiffs have done the calculations necessary to apply that table to Mr. Schleibaum's situation to derive a damage figure.

The most salient point here is that plaintiff's Rule 59 motion was the first time they directed the court's attention to this information. Plaintiffs have never been interested in pursuing this case for the minimal value of those premiums, of course, so their failure to press the point earlier is understandable. But it seems odd, to say the least, for plaintiffs to use a Rule 59

motion to tell the court it overlooked evidence they never brought to the court's attention. Plaintiffs had plenty of advance warnings that the value of the premiums might turn out to be, in the court's view, the maximum damage award in this case. Moreover, as defendant points out, the table in Exhibit 26 contains the premium rates as of *1973*. The record is silent as to whether those premium rates were still in effect in 1992 and 1993. The court would not have filled in the gap with speculation even if plaintiffs had brought the 1973 rates to the attention of the court before judgment was entered. In any event, the oversight here was not an oversight by the court. Plaintiffs chose (not unreasonably) not to develop a record on a theory of damages that would have left them at best with a few pennies on the dollar. A Rule 59 motion comes too late to change tactics and correct such oversights, and the reference to 1973 premium rates is any event insufficient to correct the oversight here.

Second, plaintiffs renew their earlier arguments that the proper remedy for Kmart's violations of ERISA notice provisions is an award of the face value of Mr. Schleibaum's group life insurance policy. These arguments address an issue that has long been apparent in this case, and plaintiffs had ample opportunity to research and argue the issue before judgment was entered. They have now chosen to use their Rule 59 motion to bolster their position by using for the first time sources that have been available since well before this action was filed. They use these sources to argue that the court's ruling is contrary to the general remedial purposes of ERISA. Plaintiffs seem to believe that if Kmart is not punished for its violation of notice requirements by paying plaintiffs several hundred thousand dollars, this court's ruling "guarantees that employers and plans may trample the rights of plan participants and beneficiaries at will, as long as they offer a method, regardless of its practicality,

that ostensibly permits participants to continue the coverage in question." Plaintiffs continue that the court's reasoning in this case "is giving the green light to corporate America to violate ERISA at will, for the only penalty will be an order to reinstate benefits or pay back premiums. . . . " Pl. Rule 59 Br. at 8.

Despite this hyperbolic rhetoric, the court is satisfied that its ruling does not spell the doom of employees' rights under ERISA. A couple of points are worth noting. First, ERISA does not spell our remedies. The Supreme Court has directed the lower federal courts to develop and apply a federal common law of contracts to fill in the gaps in the statutory provisions. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987); *Thomason v. Aetna Life Ins. Co.*, 9 F.3d 645, 647 (7th Cir. 1993). That is what the court did here by holding that any damages here would be limited to the cost of "cover" — the premiums for the conversion of the policy. Kmart was not the insurer here. Even if it wrongly denied Mr. Schleibaum's request for continued coverage (a question this court did not decide), its actions would have amounted at most to a breach of a contract to purchase insurance as an agent for the insured. It gave clear and timely notice of its intention not to provide continued coverage and of the available and reasonable means for the insured to obtain the same coverage on his own. Under these circumstances, plaintiffs could not be entitled to payment of the face value of the coverage even if they could ultimately prove a breach of the contract.

In addition, despite plaintiff's rhetoric about the need for penalties for such heinous acts as a breach of contract, they overlook the point that ERISA remains at bottom a statute dealing with contracts. This is not a realm of law in which the concept of punishment plays a significant role. ERISA reflects

a set of compromises designed to ensure that contractual commitments are honored and to provide reasonable (but not punitive) remedies when they are not. Accordingly, punitive damages are not available here, and the scope of compensatory damages is narrowly confined. After all, ERISA does not require any employer to provide any employee pension or welfare benefit plan. Whether to provide such benefits is a matter of contract and free choice. An enforcement regime that is unreasonably punitive and draconian could easily discourage employers from providing such benefits. Thus, as under the common law of contracts, the general rule is that the remedy should put the plaintiff in approximately the same situation he would have been in absent the breach. Denying these plaintiffs the windfall they seek does not threaten the rights of employees under ERISA.

Plaintiffs' motion to amend the judgment is hereby DENIED.

Date: April 15, 1997

s/ David F. Hamilton
DAVID F. HAMILTON, JUDGE
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Southern District of Indiana

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Appendix C

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APPENDIX D — ENTRY OF FINDINGS OF FACT AND CONCLUSIONS OF LAW OF THE UNTIED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF INDIANA, INDIANAPOLIS DIVISION FILED FEBRUARY 12, 1997

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

CAUSE NO. IP 95-284-C H/G

DAVID SCHLEIBAUM, SANDY SCHLEIBAUM, and JUDITH KIMMERLING,

Plaintiffs,

v.

KMART CORPORATION, as named Fiduciary of the Kmart Corporation Master Welfare Benefit Plan,

Defendant.

ENTRY OF FINDINGS OF FACT AND CONCLUSIONS OF LAW

Plaintiffs in this action seek benefits under an employee welfare benefit plan subject to the federal Employee Retirement Income Security Act, ERISA, 29 U.S.C. § 1001, *et seq.* The principal issues in the case are whether the plan administrator violated the notice requirements of ERISA in denying plaintiffs' father the benefit of payment of his life insurance premiums during a period of disability, and if so, what the appropriate remedies should be. See 29 U.S.C. § 1133 (notice requirements

when benefits are denied). This action was tried to the court on December 9, 1996. The factual record consists of the parties' filed stipulations of fact, Exhibits 1-31 and 33 (admitted by stipulation), the deposition of Dr. Aaron Rosenberg, and the trial testimony of Judith Kimmerling, Sandy Schleibaum, Rodger J. Rooney, and Donald Morford. Pursuant to Fed. R. Civ. P. 52, the court now makes its findings of fact and conclusions of law.

Findings of Fact

1. Glen Schleibaum was an automotive manager who had worked for defendant Kmart Corporation for more than twenty years. Plaintiffs David Schleibaum. Sandy Schleibaum, and Judith Kimmerling are the adult children of Glen Schleibaum. Mr. Schleibaum had his second hip replacement surgery in December 1991. At that time he went on an approved medical leave from his employment with Kmart. He never returned to work. In May 1993, Mr. Schleibaum suffered a cerebral hemorrhage. He remained hospitalized until he died on September 10, 1993.

2. The three Plaintiffs were the beneficiaries under Mr. Schleibaum's participation in a Group Term Life Insurance policy through the Kmart Life and Accidental Death and Dismemberment Plan (the "Life Plan"). Plaintiffs seek payment of $260,000 in benefits under that plan, plus interest since 1993. Kmart contends that Mr. Schleibaum's participation in the plan lapsed on November 13, 1992, one year after his medical leave began. Plaintiffs contend that Mr. Schleibaum was "permanently and totally disabled" such that he was entitled, under the terms of the Life Plan, to have had Kmart continue payment of the premiums for his participation in the Life Plan.

Appendix D

3. Defendant Kmart Corporation has been sued in its capacity as the named fiduciary of the Kmart Corporation Master Welfare Benefit Plan, an employee benefit plan governed by ERISA. The Life Plan, through which Mr. Schleibaum obtained his life insurance, was one of several employee benefit plans that Kmart administered under the Master Welfare Benefit Plan.

4. Taking the events in chronological order, Mr. Schleibaum enrolled in the Kmart Life Plan on March 12, 1989. He chose the basic coverage (approximately equivalent to his annual compensation from Kmart) plus optional coverage for three times that amount. Ex. 1. He orginally designated his wife Bertha as his beneficiary. After she died in 1991, Mr. Schleibaum named his three children (the plaintiffs here) as the beneficiaries under the plan. Ex. 2.

5. In December 1991, Mr. Schleibaum underwent surgery for his second hip replacement. His first hip replacement surgery had been done in August 1983, and that implant had failed in 1991, requiring the second surgery. Mr. Schleibaum suffered some complications after surgery but left the hospital about January 1, 1992. He returned to his home where his adult children took turns helping care for him during his recuperation. In January 1992, he suffered a dislocation of the new hip joint while sitting in an ordinary dining room chair. He then returned to the hospital for about a week. See Ex. 5.

6. Kmart had an employee benefit plan that provided for both short term and long term disability income. By letter of March 12, 1992, Kmart sent Mr. Schleibaum forms for applying for the long term disability income benefits. Ex. 4. The same letter also instructed Mr. Schleibaum to apply to the federal

Social Security Administration for disability insurance benefits under the Social Security Act. The letter also reminded Mr. Schleibaum that he was then insured for a total of $236,000 in life insurance benefits. Kmart advised him: "This coverage will remain in force during your approved medical leave of absence for a maximum of one year. Should your disability be of a permanent and total nature, you may be eligible for continued coverage under the premium waiver provisions of the policy. If approved, your group life and optional life insurance may be continued for you at no cost until age 65."

7. Mr. Schleibaum applied for long term disability income with Kmart's plan and for Social Security disability insurance benefits. His application under the Kmart plan included an attending physician's statement dated April 17, 1992, from Dr. Aaron Rosenberg, the orthopedic surgeon who performed the hip replacement. In response to the question "Is patient now permanently and totally disabled?" Dr. Rosenberg put a question mark. In his remarks, he said: "I don't know [patient's] job — he will be unable to do any type of work for at least 3 months." Ex. 5. This report was sent to Kmart in May 1992 and then to Aetna Insurance Company, which administered the long term disability benefits for Kmart. Aetna approved long term disability income benefits for Mr. Schleibaum. Ex. 7. Under the long term disability income plan, Kmart told Mr. Schleibaum he would be considered "totally disabled" during the first 24 months for which benefits were payable if "you are unable to perform the normal duties of your regular job or any other job within the Company for which you are qualified." Ex. 27 at 2 (summary plan description). In June 1992, the Social Security Administration determined that Mr. Schleibaum was eligible for disability insurance benefits under the Social Security Act beginning in May 1992. Ex. 8. Pursuant to the

Kmart disability benefit plans, Mr. Schleibaum's private benefits were reduced partially to offset the fact that he was receiving Social Security benefits. Beginning in June or July 1992, Mr. Schleibaum received private and public disability benefits totalling $3,161.16 per month. Ex. 9.

8. The summary description for the Kmart Life Plan stated the following concerning the end of coverage for an employee under the plan:

> If you are on an approved Medical Leave of Absence, the Company will continue your basic life and AD&D insurance coverage for up to one year. If you have chosen optional life and AD&D insurance coverage, the Company also will continue that coverage by paying your monthly cost during your Medical Leave of Absence for up to one year.
>
> If you become permanently and totally disabled before age 60 while actively employed, the Company will continue your basic and optional life insurance coverage until your disability ends or you reach age 65, whichever comes first. Written application for continued coverage must be made within 12 months of the date of cessation of active employment.

Ex. 25 at 6. Mr. Schleibaum's last day worked before his approved medical leave began was November 13, 1991, so Kmart continued Mr. Schleibaum's life insurance coverage at Kmart's expense for one year, until November 13, 1992. By that time, the amount of coverage had increased to a total of $260,000. The central issue here concerns the second paragraph

quoted above, and specifically the phrase "permanently and totally disabled."[1]

9. Donald Morford is employee benefits administrator for Kmart and oversees benefits for approximately 300,000 employees nationwide. Morford himself makes decisions about the benefit at issue here, continued life insurance coverage for employees who have become permanently and totally disabled. Morford decides roughly 175 to 200 such cases each year, and he has no independent recollection of his determinations concerning Mr. Schleibaum.

10. Mr. Schleibaum did not make a written application for the continued life insurance coverage based upon total and permanent disability. However, Kmart undertook its own evaluation of his eligibility for that benefit and waived the requirement of a written application. On August 28, 1992, Kmart's director of employee benefits, Donald Morford, wrote to Mr. Schleibaum.

> Your coverage under the Company's Group Term Life Insurance policy with the Aetna Life Insurance Company provides that in the event you become totally and permanently medically disabled in

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1. Plaintiffs have placed much emphasis on the phrase in this provision "until your disability ends." This language does not undermine the standard of "permanent and total disability." Improvements in medical treatments and unexpected improvements in patients' conditions allow the possibility that even a person who has been determined once to be permanently and totally disabled may later regain his or her ability to work. This possibility would exist unless the standard were applied so as to require proof to an absolute certainty. The reference does not show any fatal ambiguity in the plan.

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accordance with the plan provisions, the amount of your group life insurance will continue in force so long as such total and permanent disability continues — up to age 65.

Our review of the medical evidence provided discloses that you are not totally and permanently disabled. Your group life insurance, therefore, will not be continued by the Company.

Your group life insurance coverage through the Company will cease effective November 13, 1992 upon expiration of the maximum one year period of medical leave permitted under the Company's leave of absence policy.

Should you believe this determination is not correct, you have the right to appeal it. To do this you must write to us within 60 days of the date you received this letter and state why you wish to appeal the Company's decision. You should also forward any additional information or medical reports which you wish to have considered as part of your appeal. Should you not advise us of your wish to appeal the determination within this 60 day period, you will not be able to do so at a later date.

You may, if you wish, elect to convert all or any portion of the life insurance coverage to an individual policy, (excepting a policy of term insurance) with the Aetna Life Insurance Company provided you do so within 31 days of the date your coverage terminates. To do this you should contact

> the Aetna Life Insurance Company at (313) 637-6000 and request conversion of your group coverage.
>
> Should you have any questions concerning this matter, please advise.

Ex. 10. According to Mr. Morford, this letter was a form letter used by the Kmart employee benefits department. The only medical evidence upon which Mr. Morford based this denial was Dr. Rosenberg's attending physician form dated April 17, 1992. That report said that Mr. Schleibaum was then unable to do any kind of work and that he would be "unable to do any type of work for at least 3 months." See Ex. 5. The report did not say that he either was or was not permanently and totally disabled from any kind of work. Mr. Morford read the reference to "at least three months" as "suggesting the likelihood" that Mr. Schleibaum would recover in three months.

11. Mr. Schleibaum responded with a letter dated September 24, 1992:

> At this time I would like to appeal my medically [sic] disability.
>
> Enclosed are copies of a form sent to Aetna from my hip doctor. Also a letter from S.S. showing that they are paying on a 100% disability.
>
> I have an appointment with Dr. Rosenberg on October 15, 1992. If [there] are any forms or paper work that I can take to him to fill out to show that I am totally disabled and will never be able to return *to my job with K-Mart.* Please send them to me as soon as [possible].

Ex. 12 (emphasis added). Enclosed with Mr. Schleibaum's letter was Exhibit 11, which was an attending physician statement bearing Dr. Rosenberg's name and dated September 21, 1992. (The statement was actually filled out and signed by Dr. Rosenberg's nurse for him. See Rosenberg Dep. at 19-20). Also enclosed with Mr. Schleibaum's letter was a copy of Exhibit 8, the determination of eligibility for disability benefits by the Social Security Administration.

12. Notwithstanding the nurse's role in writing Exhibit 11, in his deposition, Dr. Rosenberg testified that the evaluation dated September 21, 1992, reflected his findings and determinations as of June 1992, when he had last seen Mr. Schleibaum. That evaluation included Mr. Schleibaum's history of hip problems and his diagnosis and treatment. Under Progress, Dr. Rosenberg's nurse checked that Mr. Schleibaum was "Improved" and "Ambulatory." Under Physical Impairment, which asked the doctor to check one of five categories ranging from no limitations on functional capacity to severe limitation, Dr. Rosenberg's nurse checked Class 4: "Moderate limitation of functional capacity; capable of clerical/ administrative (sedentary*) activity (60-70%)." Dr. Rosenberg's nurse did not check Class 5 "Severe limitation of functional capacity incapable of minimal (sedentary*) activity (75-100%)"[2] In the Prognosis section, the nurse checked that Mr. Schleibaum was "now totally disabled" both for his own job and for "any other work". She did not fill out the portion asking for a prediction of future improvement. In Remarks, Dr. Rosenberg's nurse wrote: "Pt. continues to have weak muscles around hip requiring 1 crutch for ambulation. Pt. unable to walk [more than] 1-2 blocks without resting. Unable to stand

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2. In his evaluation dated April 17, 1992, Dr. Rosenberg had checked class 5 for "severe limitations." See. Ex. 5.

[more than] 15 min.; sit extended periods, bend [more than] 75 degrees, stoop or kneel. Pt. to be re-evaluated October 15, 1992." Dr. Rosenberg did not expect Mr. Schleibaum to go back to work without his approval.

13. Kmart responded to Mr. Schleibaum's appeal in a letter from Mr. Morford dated October 12, 1992. The letter read in its entirety:

> We have received in this office your appeal of the Company's denial for continuation of life insurance benefits based on permanent and total disability.
>
> The provisions of the Group Term Life Insurance policy are as follows: The term "permanently and totally disabled" means that the employee, due to illness or injury, is not engaged in her or any other gainful occupation, and will continue to be unable, for life, to engage in any gainful occupation for which she is, or may reasonably become, fitted by education, training or experience.
>
> We must reaffirm our previous determination.

Ex. 13. Mr. Morford based this denial on the fact that the form from Dr. Rosenberg's office had checked the "Class 4" for functional limitations. He concluded that Dr. Rosenberg had misinterpreted the form in answering that Mr. Schleibaum was totally disabled from his own job and from any other work. Mr. Morford also testified that doctors often misunderstand this particular form. However, Mr. Morford did not attempt to contact Dr. Rosenberg to obtain any clarification. Nor has Mr. Morford explained why he concluded that Dr. Rosenberg had

misinterpreted the part of the form where the answers supported an award of benefits, instead of concluding that Dr. Rosenberg had misinterpreted the part of the form where the answer supported denial of benefits.

14. Mr. Schleibaum tried once more. He wrote to Kmart on October 26, 1992:

> After my last Dr.'s visit on the 15th of October, 1992, Dr. Rosenberg does not think that I will ever be able to return to work. Enclosed is a letter from Dr. Rosenberg.
>
> If possible please let me know your [decision] on my disability as soon as possible. So I will be able to do something about my life insurance by Nov. 13, 1992.

Ex. 15. The enclosed letter from Dr. Rosenberg stated in relevant part:

> Though he continues to recover from this surgery, I do not think that he will ever be able to return to active employment other than that of the most sedentary kind. I believe that in the future he will not be able to walk without the use of a cane at all times and that he will not be able to work under requirements of continuous sitting, standing or even intermittent walking.

Ex. 14.

15. Kmart responded to this, Mr. Schleibaum's last request for further consideration, with its last correspondence on the subject, a letter from Mr. Morford dated November 3, 1992.

> The provisions of the Group Term Life Insurance policy are as follows: The term "permanently and totally disabled" means that the employee, due to illness or injury, is not engaged in his or any other gainful occupation, and will continue to be unable for life, to engage in *any gainful occupation* for which he is, or may reasonably become, fitted by education, training or experience.
>
> Dr. Rosenberg's letter clearly states "I do not think that he will ever be able to return to active employment *other tha[n] that of the most sedentary kind"* (copy attached) Based on this documentation, we must reaffirm our previous determination.

Ex. 16 (emphasis in original). This letter did not invite any further appeal. Kmart may have been willing, as Mr. Morford testified, to consider further appeals by Mr. Schleibaum, but that asserted willingness has no relevance in view of the absence of any notice to Mr. Schleibaum that he had any further appeal rights.

16. Mr. Morford testified that he defers to doctors' judgments on issues of medical and functional capacity in making these benefit determinations. In this case, however, in the face of apparently inconsistent information from Mr. Schleibaum's doctor, and information that persuaded Mr. Morford that the doctor had not properly understood Kmart's form, Mr. Morford did not seek additional information. He denied benefits.

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17. After receiving Mr. Morford's letter of November 3, 1992, Mr. Scheinbaum did not pursue the life insurance issue any further. He also did not begin to pay the life insurance premiums himself, as he could have done under the terms of the Kmart plan without evidence of good health. See Ex. 25 at 7. He continued to receive long-term disability benefits from both Aetna and the Social Security Administration until he died. At the time of his death, Mr. Schleibaum also had roughly $45,000 to $50,000 in a retirement savings account with Kmart.

18. Kmart Corporation is the fiduciary that administers the Life Plan through its director of employee benefits, Donald L. Morford. The Life Plan is one of several employee benefit plans covered by the "Kmart Corporation Master Welfare Benefit Plan." Ex. 28. The Master Plan provides in part:

> *Rules of Administration.* The Company shall adopt such rules and regulations for administration of the Plan as it considers desirable provided they do not conflict with the Plan, and may construe the Plan, correct defects, supply omissions and reconcile inconsistencies to the extent necessary to effectuate the Plan, and all such action shall be conclusive. Records of administration of the Plan shall be kept, and Participants, beneficiaries, and/or Covered Dependents may examine Plan records pertaining to themselves.
>
> *Discretionary Authority.* The Company shall have discretionary authority to interpret, construe and determine the application of the Plan and its terms and to resolve all issues arising under the Plan. This discretionary authority shall include authority to (1) construe disputed or doubtful terms of the Plan

> or of any rule, regulation, form or procedure, (2) determine the eligibility of an individual to participate in the Plan, (3) determine the amount, if any, of benefits to which any Participant, spouse, beneficiary, Covered Dependent or other person may be entitled under the Plan, (4) determine the timing and manner of payment of benefits, (5) determine any matter relating to the administration of the Plan or any claim under the Plan, and (6) resolve all other issues arising under the Plan, any such determinations to be final and binding upon all persons.

Ex. 28 at 5. On September 8, 1992, Kmart adopted a Rule of Administration stating its definition of the phrase "permanently and totally disabled" for purposes of the life insurance plan. The Rule stated:

> KMART CORPORATION LIFE AND AD&D PLAN ("PLAN")
>
> RULE OF ADMINISTRATION
>
> The following is intended to represent the Company's definition of Permanent and Total Disability under the Plan.
>
> "Permanently and Totally Disabled" means that a participant under the Plan, due to illness or injury, is not engaged in his/her occupation or any other gainful occupation, and will continue to be unable, for life, to engage in any gainful occupation for which he/she is, or may reasonably become, fitted by education, training or experience.

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> The Company will review any medical documentation, related to the participant's request for a Permanent and Total Disability ("PTD"), as it deems necessary to make a determination as to a participant's eligibility for a PTD classification. The Company may also arrange for an independent medical exam when it deems it appropriate, the results of which shall be binding and conclusive. The Company may obtain updated medical information as often as it may reasonably require before determining, or continuing to determine, that a PTD exists. If the participant fails to submit to any examination or to provide sufficient proof of disability requested by the Company the participant will be considered not to be permanently and totally disabled.

Ex. 33. Before adopting this Rule of Administration, Kmart had interpreted the term "permanently and totally disabled" consistently with the written definition.

19. Mr. Schleibaum never returned to work at Kmart or elsewhere. On May 6, 1993, Dr. Rosenberg again examined Mr. Schleibaum. At that time, he was walking without a walker or crutch, could walk two to three blocks at a time, and could put on his own socks and shoes. Ex. 30 at 21. Later in May 1993 Mr. Schleibaum suffered a cerebral hemorrhage. He remained hospitalized until he died on September 10, 1993. After his death, plaintiffs asked Kmart to pay the $260,000 in life insurance benefits for which Mr. Schleibaum was covered until November 13, 1992. Kmart refused, and this lawsuit followed.

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20. Mr. Schleibaum was born on April 27, 1933, so he was 58 years old at the time of the second hip replacement surgery. In 1988 he had undergone an angioplasty because of his heart condition. He was about 5'10" or 5'11" tall, and weighed between 285 and 300 pounds. While on the job in the spring of 1991, he collapsed and was hospitalized for a blood clot in his neck. He was able to return to work after that episode. In making the decision to deny benefits to Mr. Schleibaum and to affirm that decision on his appeal. Mr. Morford had not been aware of Mr. Schleibaum's angioplasty, his collapse at work caused by blood clots, the fact that he was taking blood thinning drugs, or Mr. Schleibaum's weight.

21. Given the functional limitations as stated by Dr. Rosenberg in September and October 1992, it is unlikely that Mr. Schleibaum could ever have returned to his former Kmart job as an automotive manager, even with accommodations for his limitations. Kmart never sought an independent medical examination of Mr. Schleibaum pursuant to the Rule of Administration that applies to the definition of "permanently and totally disabled." Kmart also never contacted Dr. Rosenberg to ask him to clarify his opinion concerning Mr. Schleibaum's prognosis. As an orthopedic surgeon, Dr. Rosenberg based his own evaluations of Mr. Schleibaum solely on his hip problem. He did not consider how Mr. Schleibaum's functional capacity might have been affected by other conditions in combination with that. Dr. Rosenberg did not know in 1992 whether Mr. Schleibaum would be able to progress to the point of being able to do sedentary work of any kind. When asked in a deposition taken in November 1996, more than three years after Mr. Schleibaum's death, Dr. Rosenberg could not form an opinion about whether Mr. Schleibaum was permanently and totally disabled accordingly to Kmart's definition as of October 1992.

22. Among the jobs for the approximately 300,000 people that Kmart employs, some jobs are properly classified as sedentary with a sit/stand option. Kmart has not identified any specific jobs that Mr. Schleibaum might have been capable of performing if his recovery from his second hip replacement surgery had continued. Nor was Mr. Schleibaum's application for the life insurance coverage submitted for review by any vocational expert who might have opined as to his employability.

23. At this point it is impossible to say with confidence whether Kmart could have successfully accommodated Mr. Schleibaum's limitations and returned him to some other job in Kmart. On this record, the evidence simply does not permit a finding (*de novo* or otherwise) as to whether Mr. Schleibaum was permanently and totally disabled for purposes of the Life Plan.

Conclusions of Law

1. This court has jurisdiction over the parties and over the subject matter of this action pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132.

A. ERISA Notice Requirements

2. In denying Mr. Schleibaum the continued life insurance program coverage based on disability, Kmart violated his rights to meaningful notice under ERISA.

3. When denying benefits under an ERISA plan, the administrator must provide in its notice to the claimant specific reasons for the denial to ensure the claimant receives an

opportunity to obtain "a full and fair review" by the administrator. *Halpin v. W.W. Granger, Inc.*, 962 F.2d 685 (7th Cir. 1992). Under ERISA, a notice denying benefits must achieve the following:

> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1133; see *Halpin*, 962 F.2d at 689.

> 4. Regulations require that the initial notice of a claim denial action contain:
>
> (1) The specific reason or reasons for the denial;
>
> (2) Specific reference to pertinent plan provisions on which the denial is based;
>
> (3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary
>
> (4) Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.

29 C.F.R. § 2560.501-1(f); see *Halpin*, 962 F.2d at 689. In *Halpin*, the Seventh Circuit recognized that "substantial compliance" with these requirements could suffice because not every procedural error would affect a claimant's rights. 962 F.2d at 690. Under *Halpin*, however, the issue is whether the notice of denial of benefits gave the claimant an explanation that was adequate to ensure meaningful review of that denial, and the application of these standards is necessarily a fact-intensive inquiry." *Id.* Accord, *Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 382 (7th Cir. 1994) (administrator's failure to give adequate notice did not require relief where claimant had received adequate explanation for denial of benefits).

5. Exhibit 10 is Mr. Morford's initial letter denying Mr. Schleibaum the continued life insurance coverage. As "explanations" go, that denial letter was about as conclusory as might be imagined. It failed to state the "specific reason" for the denial, and it provided no description of "any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary." See 29 C.F.R. § 2560.503-1(f)(1) and 3. As the Seventh Circuit said in *Halpin*: "Bare conclusions are not a rationale." 962 F.2d at 693. The reference in the letter inviting "any additional information or medical reports which you wish to have considered as part of your appeal" is exactly the sort of "blanket request for 'additional medical information' " that the Seventh Circuit held inadequate in *Halpin*, see 962 F.2d at 691.

6. Mr. Schleibaum's letter appealing this denial shows that Mr. Schleibaum did not understand the basis for Kmart's denial of his claim for benefits — *viz.*, Kmart's belief that he would be able to perform other kinds of work in the future, even if he

would not be able to return to his old job at Kmart. Mr. Schleibaum emphasized in Exhibit 12 that he would never be able to return to *his job with Kmart*.

7. Kmart argues that any defects in the original denial letter could be cured by Exhibit 13, Mr. Morford's response to Mr. Schleibaum's letter of appeal. It is not clear, as a matter of law, that a notice denying an appeal can cure defects in an original notice of denial of benefits. See *Halpin*, 962 F.2d at 693 (noting that regulations apply to denial letter itself, and finding that later letter was inadequate even if it might theoretically remedy original deficiencies). However, Mr. Schleibaum had not actually sent Kmart an application for the continued life insurance coverage before receiving Kmart's first denial letter. Thus, in this case, Kmart itself actually initiated the application process by undertaking its own review of the available medical evidence and then notifying Mr. Schleibaum of its initial determination to deny the continued life insurance coverage. Accordingly, the October 12, 1992, letter was Kmart's first response to a formal request by Mr. Schleibaum for this benefit. Under these circumstances, even though that letter is in the form of a denial of an appeal, the court has considered whether the October 12, 1992, letter satisfied the ERISA notice requirements for a denial of benefits. It did not. It provided no explanation. It merely quoted the relevant policy language. It did not identify the type of medical evidence that could lead to a grant of the benefit. Perhaps even more important, the letter did not invite any further review.

8. The most complete explanation that Kmart gave Mr. Schleibaum is set forth in Exhibit 16, the November 3, 1992, letter from Mr. Morford. The letter quotes the definition of permanent and total disability in the September 8, 1992 Rule

of Administration. The letter also quotes Dr. Rosenberg's letter which did not rule out the possibility that Mr. Schleibaum might be able to return to work of "the most sedentary kind." Kmart argues that this last letter cured the problems with the first letter because it finally identified the way in which the medical evidence submitted by Mr. Schleibaum failed to satisfy the stringent standard in the policy. Relying on the language from *Donato v. Metropolitan Life*, 19 F.3d at 382, Kmart has argued that, if the three letters are taken together, they "at least implicitly made clear to Mr. Schleibaum exactly what type of medical information he needed to submit, that is, any documentation that would show there was no expectation of him engaging in any type of gainful employment, including sedentary employment, then or in the future." Def. Post-trial Br. at 13-14.

9. The court will assume for purposes of argument that Kmart is entitled to the benefit of any doubt about Mr. Schleibaum's ability to figure out the "implicit" notice of the type of medical information needed. Even if the court indulges in that assumption, Kmart's attempt to read the three letters together to find "substantial compliance" fails. Kmart's theory would require this court to stretch *Donato* beyond recognition, and would allow plan administrators to turn the application process into an endurance contest that the plan administrator could win as long as it professed a willingness to continue to consider further requests by the employee. ERISA requires notice that is meaningful for the employee. For the notice to be meaningful, the employee must be in possession of three critical pieces of information at the same time, and at that time there must still be a meaningful opportunity for further appeal and full and fair review. See *Donato*, 19 F.3d at 382 (substantial compliance was sufficient where employee had all requisite

information before any dispositive deadline passed and he was still afforded a later opportunity for full and fair review). Those three pieces of information are the specific reasons for the denial (including a specific reference to the pertinent plan provision), a description of the type of additional information that would be needed to establish entitlement to the benefit, and the procedures for pursuing further review of the denial. *Donato* makes clear that courts may find substantial compliance even if the three pieces of information are not all in the same document. The key requirement is that the employee must have had all the information at a time when it could still do him some good.

10. The August 28, 1992, initial denial letter told Mr. Schleibaum about his right to appeal the denial of benefits. But that letter gave no explanation of the reasons for the denial of benefits, the information needed to obtain the benefits, or why such information would be needed. Ex. 10. The October 12, 1992, letter from Kmart was the formal denial of his appeal. It also gave no explanation, and it invited no further review. Ex. 13. The November 3, 1992, letter — the one that merely used underlining as an explanation and provided what Kmart now calls the "implicit" notice of the information needed for an appeal — also did not invite any further response. It provided no indication at all that Kmart might be willing to reconsider its decision in light of the additional evidence that it "implicitly" told Mr. Schleibaum might be sufficient. Ex. 16. Mr. Morford's trial testimony professing his willingness to continue (apparently indefinitely) to consider additional information from Mr. Schleibaum adds nothing to Kmart's claim of "substantial compliance" with ERISA's notice requirements.

11. This failure to ensure that Mr. Schleibaum had *at the same time* the reasons for the denial, the specific type of information needed to appeal successfully, and the information about how to appeal is not a mere technical or procedural error. ERISA requires plans to provide an internal appeals process that gives a claimant "a full and fair review of the claim and its denial." 29 C.F.R. §2560.503-1(g)(1). The purpose of ERISA's notice requirements is to ensure "that when a claimant appeals a denial to the plan administrator, he will be able to address the determinative issues and have a fair chance to present his case." *Halpin*, 962 F.2d at 689. That purpose is not served when the employer uses only form letters, as it did here. That purpose also is not served when the employer later sends a letter with a more specific explanation — but one that only "implicitly" identifies the needed information — only after the employer has already decided the appeal, and without inviting any further review or appeal. Despite Kmart's assertions after the fact, in this litigation, that it would have been willing to consider any further information, the court cannot fault Mr. Schleibaum for failing to try any more after receiving the November 3, 1992 letter. ERISA requires claimants to take reasonable steps to protect their interests. It does not require them to persist indefinitely in the face of repeated denials of their claims, especially when those denials fail to comply with ERISA's notice requirements.

12. Kmart argues that requirements set forth in *Halpin* do not apply because the claimant there submitted evidence of total disability and Mr. Schleibaum did not. This is not a case where a plan administrator was required to evaluate conflicting medical evidence. In such cases a more detailed explanation may be necessary. But the absence of conflicting evidence does not relieve a plan administrator from the statutory notice

requirements. After all, the very purpose of the notice requirements is to ensure that the employee has an *opportunity* to submit additional, and perhaps conflicting, medical evidence. Mr. Schleibaum submitted evidence from his doctor that Mr. Schleibaum at least believed was sufficient to establish a qualifying disability. And to reach his original denial decision, Mr. Morford had to decide whether Dr. Rosenberg misinterpreted the part of the Kmart form that supported an award of benefits or the part that supported denial. Mr. Schleibaum was entitled to a notice complying with the statutory requirements discussed in *Halpin*. To give Mr. Schleibaum a fair opportunity for a meaningful review of the denial, Kmart was required to give him timely notice of the specific reasons for the denial and the type of medical evidence necessary for a successful appeal. Kmart's letters to Mr. Schleibaum did not satisfy ERISA's notice requirements.

B. Remedies

13. The more difficult problems in this case concern the appropriate remedy, if any, for Kmart's violation of the notice requirements. Kmart argues that no remedy is appropriate without evidence showing that Mr. Schleibaum was in fact permanently and totally disabled. Even if such evidence had been offered, argues Kmart, the only appropriate remedy would be a remand to Kmart as the plan administrator to evaluate such evidence. See generally *Kent v. United of Omaha Life Irs. Co.*, 96 F.3d 803, 807 (6th Cir. 1996) (procedural violations of ERISA generally entail substantive remedies only when some useful purpose would be served; no remand to plan administrator required where plaintiff had failed to offer new evidence to establish disability). Finally Kmart argues, under no circumstances could the court actually award the face value

of the life insurance coverage here. Plaintiffs contend that Kmart should be held responsible for the absence of definitive evidence as to whether Mr. Schleibaum was permanently and totally disabled. Plaintiffs also ask the court to undertake a *de novo* review of Mr. Schleibaum's eligibility for benefits. Finally, they contend that the appropriate remedy here is the face value of the life insurance coverage.

14. At this juncture, after Mr. Schleibaum's death, it would be impossible for the court to determine whether Mr. Schleibaum was in fact permanently and totally disabled in the autumn of 1992. Dr. Rosenberg did not make that determination because he considered only Mr. Schleibaum's hip condition and the complications resulting directly from that. Mr. Morford made his determination based on incomplete information, and he was responsible for at least a substantial part of the gaps in the record that were caused by the violation of the notice requirements. In addition, Mr. Morford never sought or obtained information concerning Mr. Schleibaum's actual employability. Even looking at the evidence in the light most favorable to Kmart's denial of benefits, it appeared that Mr. Schleibaum's condition had been improving after his hip operation, but that he would still have been limited to sedentary work with a sit/stand option. That is generally a small fraction of sedentary jobs. In addition, sedentary jobs can still involve some walking and standing, and Mr. Schleibaum's inability to tolerate continuous sitting could be a significant limitation. Cf. 20 C.F.R. § 404.1567(a) (defining sedentary work for purposes of Social Security disability benefits). Finally, the evidence at trial indicated that Mr. Schleibaum continued to have substantial limits on his stamina several months after his second hip operation. Limited stamina can easily make the difference as to whether a person is able to engage in gainful employment.

Determining whether such a sedentary job with a sit/stand actually existed (or was available) that Mr. Schleibaum could actually have performed was beyond the scope of the inquiry undertaken by Kmart. See *Schaub v. Consolidated Freightways, Inc. Extended Sick Pay Plan*, 895 F.Supp. 1136, 1144-45 (S.D. Ind. 1995) (plan administrator needed vocational information to determine eligibility for continued disability income benefits).[3]

15. The problem here is one of burden of proof. Plaintiffs cannot show now that Mr. Schleibaum was permanently and totally disabled. Defendant cannot show that Mr. Schleibaum was not. The problem is also closely tied to the appropriate standard of review. If the appropriate remedy here is a remand to the plan administrator for a fresh look at the case, such a remedy would plainly be pointless. Kmart has made it clear

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3. Kmart complains in its reply brief that it should not have to review "employability" to determine eligibility for this continued life insurance coverage. Kmart even faults plaintiffs for failing to articulate such a "nexus between employability and life insurance." Def. Post-trial Reply Br. at 4-5. This argument is downright strange. It is Kmart's own plan, after all, that *defines* permanently and totally disabled in terms of whether the employee is capable of engaging in any type of gainful *employment*. See Ex. 33. Kmart is correct that ERISA leaves it free to write its own plan and to use that substantive standard for eligibility for the benefit it chooses to do so. ERISA does not require Kmart to offer this disability benefit at all. But in this case, Kmart chose to extend this benefit. It also chose not to base eligibility for this benefit on another determination that someone else would make, such as the less stringent standards applied in Kmart's short-term and long-term disability income plans and by the Social Security Administration. Kmart was free to make that choice. But having chosen to use a standard that may be expensive for it to administer in cases like this one, Kmart cannot complain if courts direct it to consider employability information that is essential to apply the standard accurately in those cases.

that it would not determine that Mr. Schleibaum was eligible for benefits without seeing new evidence of a type that plaintiffs cannot possibly find or produce. Plaintiffs therefore argue that the court should decide this matter *de novo*, and they urge the court to hold the lack of evidence against Kmart because that lack resulted (at least in substantial part) from Kmart's violation of the notice requirements. The parties have devoted a considerable amount of their briefs to the appropriate standard of review and the choice between remand and *de novo* determination. Kmart relies on *Wolfe v. J.C. Penney Co.*, 710 F.2d 388, 394 (7th Cir. 1983), where the Seventh Circuit held that a district court could not, under similar circumstances, determine eligibility in the first instance for a new benefit that the employee had not received before. Plaintiffs rely on *Halpin v. W.W. Granger, Inc.*, 962 F.2d at 697, which allowed *de novo* review of an administrator's decision to terminate a benefit that the employee had already been receiving. As to this particular issue, this case falls right in between *Wolfe* and *Halpin*. From Mr. Schleibaum's perspective, Kmart's decision was terminating a benefit that he had been receiving for the first year of his medical leave, regardless of precisely which plan was providing the benefit. From Kmart's perspective, Mr. Schleibaum was seeking a determination of eligibility for the first time. The obscurity of the question arises from the fact that Kmart wrote its benefit plans so that the standard of disability for continued receipt of life insurance coverage rose substantially after the first year of coverage during a medical leave.

16. The court concludes that these questions need not to be resolved to decide this case. The court will assume for purposes of argument that the burden of proof as to Mr. Schleibaum's condition should fall on Kmart. If the burden of

proof were placed on plaintiffs, they could not meet that burden as a result of the combination of Kmart's violation of ERISA notice requirements and Mr. Schleibaum's death. See *Leigh v. Engle*, 727 F.2d 113, 137-39 (7th Cir. 1984) (where plan fiduciaries violated ERISA by using plan assets to assist their own hostile corporate takeovers, court would resolve in favor of plan beneficiaries any factual uncertainties relevant to a remedy). The court will also assume for purposes of argument that it would have the power to make a *de novo* determination of Mr. Schleibaum's eligibility for the benefit, rather than remanding the case to the plan administrator. Even making those assumptions in favor of plaintiffs, the appropriate remedy here could not be the remedy plaintiffs seek — the face value of the life insurance.

17. Whatever its other merits or faults, Kmart's decision in this case was both timely and clear. Mr. Schleibaum knew that continued life insurance coverage would require him to pay the premiums himself. The evidence shows that that was in fact a reasonable and practical alternative for Mr. Schleibaum at that point. He was receiving disability income from both the Social Security Administration and the Kmart disability plan, and he had substantial cash in a retirement savings account. In view of his very poor health, it is unlikely that Mr. Schleibaum could have brought life insurance on his own. However, the Kmart plan gave him the opportunity to simply convert his existing coverage to a policy for which he would pay the premiums without additional proof of good health or insurability. All he had to do was sign up and pay the premiums. The record is silent about his reasons, but he chose not to do so. Kmart was responsible, at most, for failing to continue paying Mr. Schleibaum's life insurance premiums. After Kmart gave him clear and timely notice that it would not be paying

those premiums and that he had the right to continue the coverage himself by paying the premiums, the lapse in the life insurance coverage was Mr. Schleibaum's own choice. The responsibility for the choice must fall on his beneficiaries rather than on Kmart.[4]

18. Plaintiffs understandably have had little interest in pursuing this case to obtain the meager benefits of a few months' worth of life insurance premiums, and the record before the court does not show the amount of such premiums. The greatest remedy to which plaintiffs might be entitled is payment of those premiums. The absence of evidence as to the correct amount of those premiums constitutes a failure of proof as to this essential element of the plaintiffs' claim. Accordingly, the court will enter judgment for defendant.

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4. To support their claim for the face value of the lapsed insurance policies, plaintiffs cite *Filipowicz v. American Stores Benefit Plans Comm.*, 56 F.3d 807 (7th Cir. 1995), and *Quesinberry v. Life Ins. Co. of North America*, 987 F.2d 1017 (4th Cir. 1993) (*en banc*). Neither case addressed the question presented here and neither provides guidance on this issue. In *Filipowicz*, for example, the district court and Seventh Circuit found that the plaintiff's late wife had been entitled to continued life insurance coverage, but there was no indication in that case that the plaintiff's wife (who had been terminally ill) had any right to continue the coverage after the wrongful denial. This case is more properly comparable to a breach of a contract to procure insurance where the breaching party has given the other party ample notice of the breach so that "cover" is possible by making alternate arrangements for insurance. In such cases, the measure of damages is the cost of "cover." The breaching party does not become, in effect, the insurer.

Appendix D

C. Attorneys' Fees and Costs

19. Both sides have asked for an award of attorneys' fees and costs in this case. Plaintiffs are not entitled to such an award in view of their lack of ultimate success on the merits. Defendant also is not entitled to an award of fees and costs. Plaintiffs have shown that Kmart violated ERISA's notice requirements under circumstances that made it impossible to remedy that error by merely seeking additional information and resubmitting it to Kmart for a fresh look. In addition, the evidence indicates that the violation of ERISA's notice requirements was not the result of some inexplicable failure in Kmart's administrative system. It was the result of Kmart's use of bland and general form letters in dealing with a benefit that uses eligibility standards that are difficult and expensive to administer in accordance with ERISA's requirements. An award of fees and costs under these circumstances would not be equitable.

Conclusion

For the foregoing reasons, the court will enter final judgment in favor of defendant Kmart, but the parties shall bear their own costs.

Date: February 12, 1997

s/ David F. Hamilton
DAVID F. HAMILTON, JUDGE
United States District Court
Southern District of Indiana

APPENDIX E — FINAL JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF INDIANA, INDIANAPOLIS DIVISION FILED FEBRUARY 12, 1997

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

CAUSE NO. IP 95-284-C H/G

DAVID SCHLEIBAUM, SANDY SCHLEIBAUM, and JUDITH KIMMERLING,

Plaintiffs,

v.

KMART CORPORATION as named Fiduciary of the Kmart Corporation Master Welfare Benefit Plan,

Defendant.

FINAL JUDGMENT

This matter having been tried before the court, and the court having this day issued its findings of fact and conclusions of law, it is hereby

ORDERED, ADJUDGED, AND DECREED that plaintiffs David Schleibaum, Sandy Schleibaum, and Judith Kimmerling, take nothing by their complaint against defendant Kmart Corporation, and that this action be DISMISSED WITH PREJUDICE. All parties bear their own costs.

Appendix E

Dated: February 12, 1997

s/ David F. Hamilton
DAVID F. HAMILTON, JUDGE
United States District Court
Southern District of Indiana

APPENDIX F — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT DENYING PETITION FOR REHEARING EN BANC DECIDED SEPTEMBER 18, 1998

United States Court of Appeals

FOR THE SEVENTH CIRCUIT
CHICAGO, ILLINOIS 60604

Nos. 97-2202

Decided: September 18, 1998

Before

Honorable Daniel A. Manion, *Circuit Judge*

Honorable Michael S. Kanne, *Circuit Judge*

Honorable Ilana Diamond Rovner, *Circuit Judge*

DAVID SCHLEIBAUM, SANDY SCHLEIBAUM, and JUDITH KIMMERLING,

Plaintiffs-Appellants,

v.

KMART CORPORATION, as Named Fiduciary of the Kmart Corporation Master Welfare Benefit Plan,

Defendant-Appellee.

Appendix F

Appeal from the United States District Court
for the Southern District of Indiana,
Indianapolis Division

No. 95 C 284

David F. Hamilton, *Judge*

ORDER

On consideration of the petition for rehearing with suggestion for rehearing en banc filed by defendant/appellee on September 8, 1998, no judge in active service has requested a vote thereon, and all of the judges on the original panel have voted to deny the petition. Accordingly,

IT IS HEREBY ORDERED that the petition for rehearing with suggestion for rehearing en banc be, and the same is, hereby DENIED.

APPENDIX G — STATUTORY PROVISIONS INVOLVED

UNITED STATES CODE ANNOTATED
TITLE 29, LABOR
CHAPTER 18 — EMPLOYEE RETIREMENT INCOME SECURITY PROGRAM
SUBCHAPTER I — PROTECTION OF EMPLOYEE BENEFIT RIGHTS
SUBTITLE B — REGULATORY PROVISIONS
PART 5 — ADMINISTRATION AND ENFORCEMENT

29 U.S.C. § 1132

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought —

(1) by a participant or beneficiary —

(A) for the relief provided in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other

appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) of this section or under subsection (i) or (1) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of

* * *

Appendix G

29 U.S.C. § 1133

§ 1133. Claims procedure

In accordance with regulations of the Secretary, every employee benefit plan shall —

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such a denial, written in a manner calculated to be understood by the participant.

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.